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ILLINOIS STATE MEDICAL SOCIETY

Volume 165 No 1 January 1984

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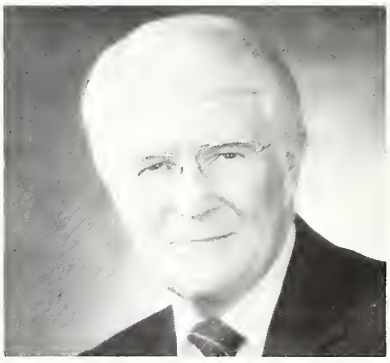
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President's Page

Report from the AMA Interim Meeting



The AMA Delegation to the House of Delegates attended the Interim Meeting of this assembly from December fourth through seventh of 1983. Events of continuing significance surfaced again during these days. Your representatives entered into vigorous debates and presentation of testimonies before reference committees and sessions of the House of Delegates.

President Frank J. Jirka, Jr., M.D. addressed the opening session and shared his observations on the commonality of concerns throughout the states he has visited during the first half of his presidency. He recounted the "well traveled roads" of that cacophony of alphabetized acronyms (HMO-PPO-EPO-DRG-ETC) that face the medical profession in this time. He urged that physicians maintain constant awareness of an ongoing effort to change the Medicare assignment method and asked that they be prepared to enter into legislative activities designed to present and document medicine's position before Congress and the administration.

Closely following that address we heard from the Secretary of the Department of Health and Human Services, the Hon. Margaret M. Heckler, who presented a recital of the Administration's concerns about health care issues. She gave priority to the Administration's feelings about the cost of medical care and opined that the options were only two: centralization or decentralization. In making her choice about these two systems, she stated, "you, I and the American public, are best served by a decentralized system where physicians sell medical services to many competing buyers, both public and private." She further observed that competition is the staunch ally of medicine's freedom and medicine's future. Efforts to accomplish these goals will be encompassed in actions to enact the Administration's tax cap proposal, enhance the already enacted legislation that eases participation in HMOs and other competitive medical plans and promote a proposed new Medicare voucher plan, all encouched in the concept of "choice."

It is our obligation to critically analyze these proposals of free enterprise support in light of maintaining the best qualities of our medical care delivery system existing in a free—not government subsidized—competitive system. All systems must stand on their own merit rather than on the basis of advantages provided by outside support. I interpret her remarks to indicate that our Potomac watchers still need to maintain their high degree of excellence in observation of government trends.

Lastly, three significant policy decisions were made by the House of Delegates at the time of the interim session.

The first dealt with potential interference by DRG and length of stay factors in renewal of staff appointments. The House stated "that it be the policy of the American Medical Association that reappointment to the hospital medical staff and peer review for quality assurance in hospital medical care be based on all elements of physician performance and not solely on any limited assessment (e.g., conformity to DRG or length of stay criteria, etc.)."

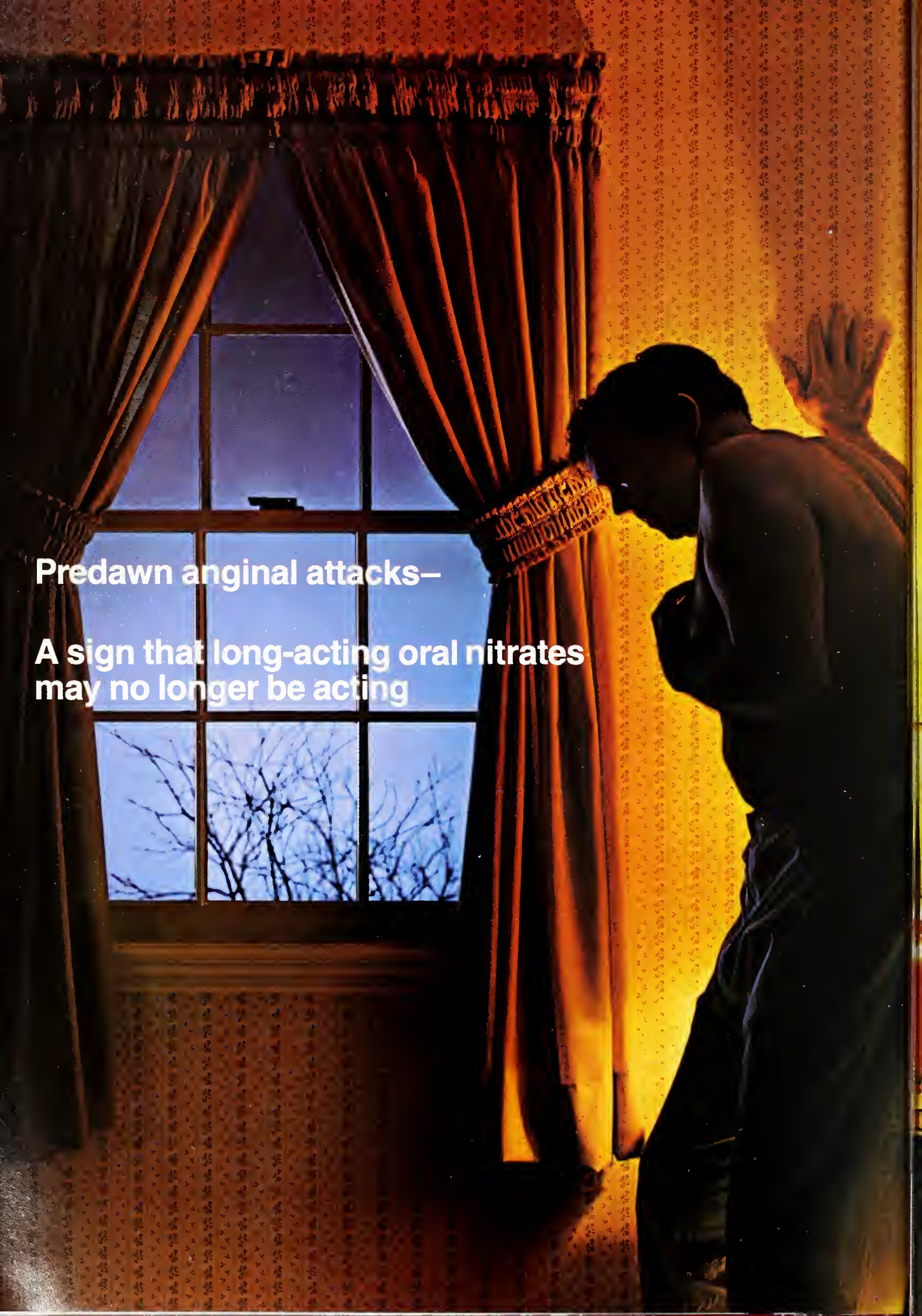
Second, a commitment to a policy will be carried by our commissioners to the JCAH regarding the accreditation manual for hospitals (medical staff chapter) in which we state "that it be the policy of the American Medical Association that the hospital admitting privilege be granted in accordance with state law and in accordance with the criteria for standards of medical care established by the individual hospital medical staff."

And third, a policy that may serve the membership well in the future relationships and become part of all of our lives as we deal with third party payers. This policy states that "the American Medical Association House of Delegates support the right of the physician to balance bill a patient for any care given regardless of the method of payment or contractual agreement, where permissible by law."

Many of these issues may need appraisal at the forthcoming Annual Meeting of the Illinois State Medical Society House of Delegates. Therefore I encourage the membership to help their delegates draft appropriate resolutions to express their concern to this policymaking body for our state. We all will be waiting to participate in the discussions about the relative positions of UCR (Usual, Customary or Reasonable) versus Indemnity Payment (as a schedule of benefits) in the continuing pluralistic system of patient/physician interaction that we wish to maintain. ◂

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Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued.

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Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26)
5 mg/24 hr	25 mg	10 cm^2	7 Systems (NDC 0083-2105-07)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26)

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C I B A

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

Abstracts of Action

November 11, 1983 *Decatur, Illinois*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

IDPA FULL SERVICE RFPs

IDPA has invited proposals for full service capitation programs. A review panel has reviewed 28 proposals and identified seven which could be considered solid and implemented with little or no modification prior to contract negotiations with the Department. A second group were deemed to require some degree of modification and the bidders were requested to submit their bids clarifying certain points, within six months. A third group of proposals were deemed unacceptable.

The Department has indicated it plans to begin negotiations with bidders in December, 1983, addressing marketing, plan development, reporting and reimbursement, for a phase-in of contracts beginning in February, 1984.

In January, 1984, the expert review panel will be restructured to consider additional proposals. Additionally, the Department has received 61 bids to provide inpatient only services on a prepaid basis. This is under development and is being monitored.

The Board directed continued monitoring and recognized with commendation the work of Fred Z. White, M.D., in assuming the difficult task of reviewing all the proposals as chairman of the review committee.

LABORATORY VOLUME PURCHASE PLAN

As part of its efforts to restructure the Medical Assistance Program, IDPA is proposing to develop a volume purchase plan for laboratory services. Only a limited number of laboratories, selected by competitive bidding, would stay in the Public Aid program. The Board reviewed a report on this matter and adopted the position that ISMS not develop a LVPP for the Department, as requested. In addition, if the Department does develop this plan, ISMS will review it and negotiate changes, as necessary, to assure that quality lab services remain available to the indigent.

JCAH ACCREDITATION MANUAL FOR HOSPITALS

Over a period of two years the JCAH has been revising the Guidelines in the Accreditation Manual for Hospitals, pertaining to the section covering organization of medical staffs. A fourth proposal was reviewed and the Board ratified submission of a letter of comment. While the newest revision resolved most previously existing concerns, comment was made on the need to continue to assure that medical problems be in the purview of the physician.

MEDICAL MANPOWER

The Board considered an extensive report detailing a study of physician retention in Illinois. Over 1000 residents were surveyed to determine factors present in the choice of practice location. The thrust of this was to demonstrate that Illinois, as an exporter of physicians to other states, is not reaping the benefit of its investment in medical education.

As a result, the Board agreed:

- To make current names and addresses of Illinois medical graduates available to physician-sponsored efforts to recruit physicians for Illinois communities.
- To consider expansion of the job fair concept and reinforce current physician recruitment services.
- To disseminate results of the survey to the membership as appropriate, to the General Assembly, and to other Illinois recruitment efforts.
- To encourage the Medical Student Section and Resident Physician Section to promote greater membership and participation in ISMS activities for their respective groups.
- To authorize printing of a recruitment booklet, "A Little Luck is Not Enough," to assist those engaged in physician recruitment efforts.

OTHER ACTIONS

In other actions, the Board:

- Directed that ISMS: (1) Support the current system for awarding the AMA Physician Recognition Award rather than implementing a new system of "designated CME credits," and (2) Inform the AMA of this position.
- Created a Task Force on ISMS-sponsored Membership Insurance Programs, to explore the feasibility of ISMS or an affiliated organization assuming in-house administration of all Society-sponsored insurance programs.
- Authorized introduction to the Interim Session of the AMA House of Delegates a Memorial Resolution in honor of Dr. Walter Bornemeier, past-president of the AMA, who died recently.
- Accepted a proposal to provide a Professional Office Insurance Package for physician members of ISMS, as a new sponsored program.
- Approved requests for changes in membership status requested by various county medical societies, and filed the financial report.

NOMINATIONS AND APPOINTMENTS

The Board acted to make the following nominations and appointments:

- Dr. Robert Hartman, Jacksonville, appointed to the ISMS Task Force on Health Professions.
- Dr. Geoffrey Bland, Springfield, appointed to the ISMS Medical Legal Council.
- Dr. Paul Lorenz, Carbondale, nominated for IHA Council on Hospital Medical Staffs, to replace Dr. Jerry Ingalls, who is now a member of the IHA Board.
- Dr. Michael Murphy, Belleville, appointed to the ISMS Impaired Physician Panel.

INFORMATION ITEMS

The Third Party Payment Processes Committee presented a report on the IDPA Bureau of Program Integrity. The TPPPC is concerned that IDPA provide an avenue for a physician subjected to Program Integrity Review to appeal to a physician review panel. IDPA has expressed an intent to expand its Peer Review program to include two Peer Review Committees, one to review quality of care issues and the other to oversee its exception review program. IDPA is seeking recommendation for a minimum of 10-15 physicians to serve on each panel. Additionally, the IDPA indicated it would develop an internal mechanism to inform the State Medical Advisory Committee (SMAC) of its program integrity activities. TPPPC believes that IDPA's attempts to involve more practicing physicians in the Appeals Process may eliminate some of the traditionally unilateral aspects of the audit process. ISMS will attempt to obtain the names of physicians interested in serving as IDPA reviewers.

The TPPPC also reported that IDPA submitted a draft RFP to provide complete physician care and case management for recipients on a prepaid capitation basis. Subsequent to review, the IDPA was informed that the RFP was not acceptable to ISMS because it appeared to discriminate against the small group and solo practitioner. IDPA recognized the concerns cited by ISMS and has requested that the Society work with them to formulate a new proposal for primary ambulatory care on a prepaid basis.

The Executive Administrator reported that a Professional Liability Membership Opinion Survey has been mailed to over 12,000 regular dues-paying members and residents. While the mail survey should prove to be a useful communications tool, Market Opinion Research has selected a random sample of 300 members/policyholders to be interviewed by telephone. The phone survey will provide ISMS the most scientifically accurate information regarding Illinois physicians' attitudes regarding professional liability problems.

He also reported that subsequent to petitions for reconsideration in June, Judge Gomberg affirmed his earlier decision that the Medical Studies Act was unconsitutional. This was taken on appeal to the Illinois Supreme Court, and based upon Board authorization, ISMS filed leave to enter as an amicus. The petition was granted by the Supreme Court. Legal counsel is in the process of finalizing an *amicus curiae* brief encouraging that the decision by Judge Gomberg not be allowed to stand.

NEXT MEETING

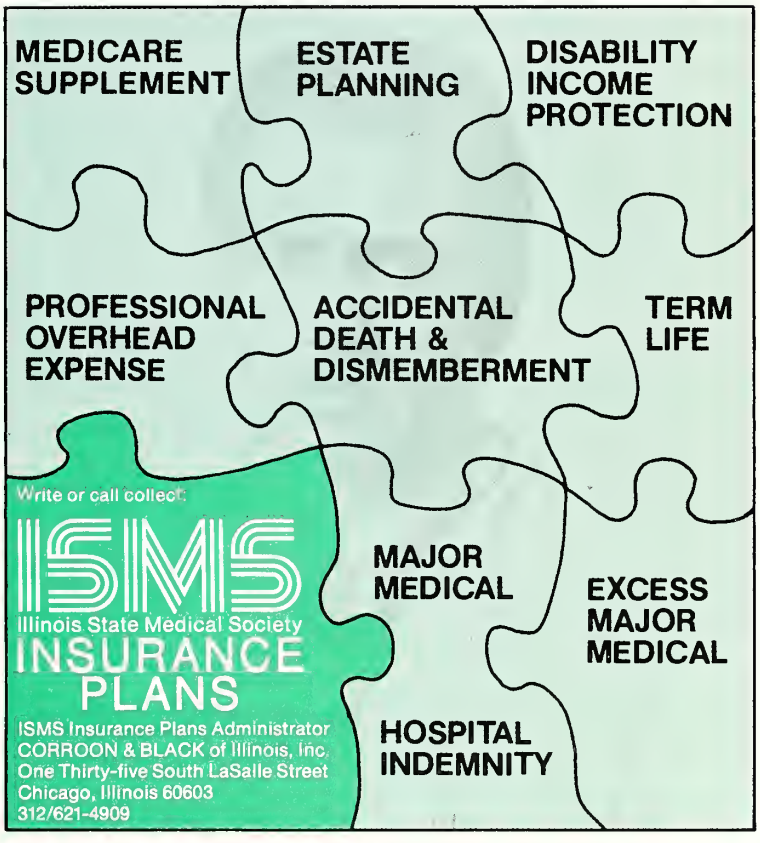
The next meeting of the Board of Trustees will be January 21-22, 1984, at the Marriott O'Hare.

SOLVE YOUR PROTECTION PUZZLE

The insurance puzzle... are there pieces missing from your picture?

As a member of ISMS, you can realize substantial benefits by participating in society-approved insurance plans. Designed and administered by professionals in cooperation with ISMS, this program could be the answer to your personal and professional needs. While your requirements receive individual attention, you also enjoy the economies of ISMS group purchasing power.

COMPLETE PROGRAM PROFILE OFFERED WITHOUT OBLIGATION



JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

Unique, once-daily formulation providing comprehensive cardiovascular protection

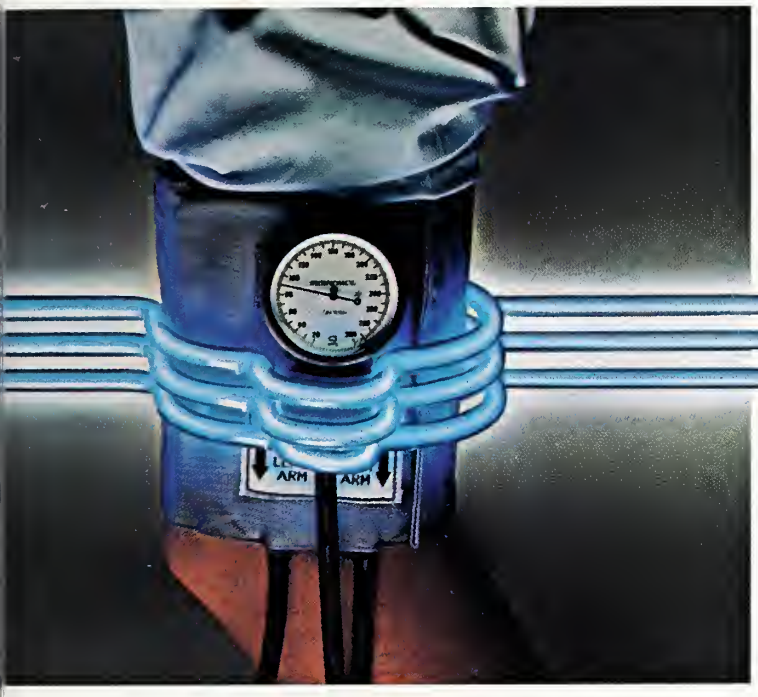
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL–with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



THE ONE™ TO COUNT ON

Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

ONCE-DAILY

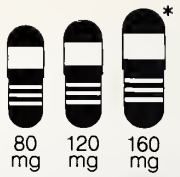
INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

Ayerst®

The one to count on for HYPERTENSION, ANGINA and prevention of MIGRAINE.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)*
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands, thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8688/883

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Medical Student Section in Action

Medical Student Perspective

ISMS sponsored a leadership conference on November 12-13 at the Holiday Inn in Decatur. The meeting was attended by perhaps three hundred physicians and other interested parties, and featured small group "break out" sessions as well as lectures and speeches for the entire audience.

Keynote speaker was Jeff Goldsmith, PhD, who gave a fabulous opening address on the changes in the economic framework of medical practice. Dr. Goldsmith remarked on how the economic power in the health care system is shifting from providers to consumers, and from this he drew the conclusion that it could interfere with the delivery of optimal health care. He noted that changes in the marketplace of health care are occurring, as the number of patient office visits levels off and the number of physicians increases. This leads to fewer patient visits per physician.

His view is that the most serious problem facing physicians and hospital administrators alike is dealing with rising expectations of health care delivery in the face of diminishing resources. He called for cooperation between physicians and administrators to assist each other in maintaining the highest quality of care. He pointed out, too, that this is necessary, stating, "to aspire to survive is a pretty mediocre objective."

Dr. Fred White and John Simon gave a presentation on ISMS professional liability initiative, explaining the trends in the number of suits and the awards given, and also recounting the steps that the ISMIE has taken to keep liability premiums from getting out of hand.

Break out sessions were held in the afternoon on health care economics, mandatory reporting/due process procedures, and Illinois government and hospital costs.

The health care economics session featured, among others, Dr. Frank Watson, president elect of the New Jersey Medical Society, giving his viewpoint on the DRG system.

In the mandatory reporting session, an in depth discussion was held on the implications and provisions of the new reporting law. Marshall Segal, M.D., J.D., and Saul Morse, J.D., explained some of the subtleties of due process with the attendees.

The Illinois government and hospital costs session centered on S.B. 495 and how it will influence physicians' hospital practice. On the panel were State Senator Prescott Bloom, the bill's sponsor, and Dr. Alfred Clementi, a member of the Technical Advisory Panel to study S.B. 495.

The dinner speaker for Saturday evening was Congressman Edward Madigan, who recounted his experiences, insight, and efforts pertaining to legislation affecting physicians. He extolled the work and efforts of the ISMS and encouraged further action and participation to help develop better, more equitable legislation to contain health care costs.

The morning general discussions were initiated with a forum on UCR versus indemnification, followed by a panel presentation on legislation and IMPAC. Each of the speakers gave special emphasis to the necessity of physician activity on a local level. Illinois Representative Judy Barr Topinka cautioned that physicians should neither relax vigilance in pursuing their objectives, nor take anyone for granted based on previous voting records.

Sunday's sessions were on loss prevention, hospital medical staff organization, and a PRO update.

The loss prevention session discussed psychological effects of the malpractice "climate" on the physician. The panel examined the expansion of Morbidity/Mortality conferences to include a malpractice segment. Risk management, it was said, should be accorded as much import as utilization review programs.

The hospital medical staff organization program considered the impact of health care delivery system changes on the relationship between physicians, hospital administrators, and hospital boards. This session featured Dr. Dennis O'Leary from Geo. Washington Univ. School of Medicine, and Dr. John Ring, AMA Board of Trustees.

The PRO update outlined the status of PRO in Illinois, which will be implemented on June 1, 1984, and how the system will relate to the Medicare prospective payment system for hospital inpatients. Dr. Warren Tuttle and others made up the panel reviewing PRO current status.

As a participant who will be affected by the health care policies in the U.S., I viewed the meeting as a foreshadowing of the problems I will eventually contend with in years to come. The meeting was well presented, timely, and informative. It certainly met the objective of alerting the audience to the changes that have occurred, and to the changes that will occur if diligent efforts are not afforded to direct and redirect the course of health care policies. There is a need for leadership, for new ideas, and for reassessing the physician's position as it stands today. Medical students, as well as physicians, should answer the call to action, and become informed of the different "alphabetized" health care systems. In this way, we should be more able to provide the leadership and new ideas to ensure that the highest calibre of medicine is maintained in the years to come. ◀

Patrick J. Merrill
Delegate,
ISMS/MSS Governing Council

University of Kansas Medical Center

presents

Barbara J. DeLateur, M.D., University of Washington-Seattle
James H. McMaster, M.D., University of Pittsburgh

at

"SPORTS MEDICINE: REHABILITATION OF THE INJURED ATHLETE"

March 15, 1984

and

Jes Olesen, M.D., Hellerup, Denmark

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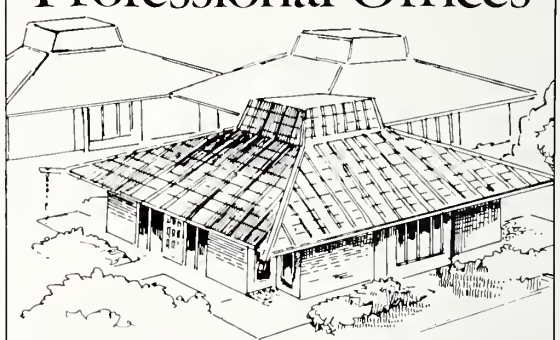
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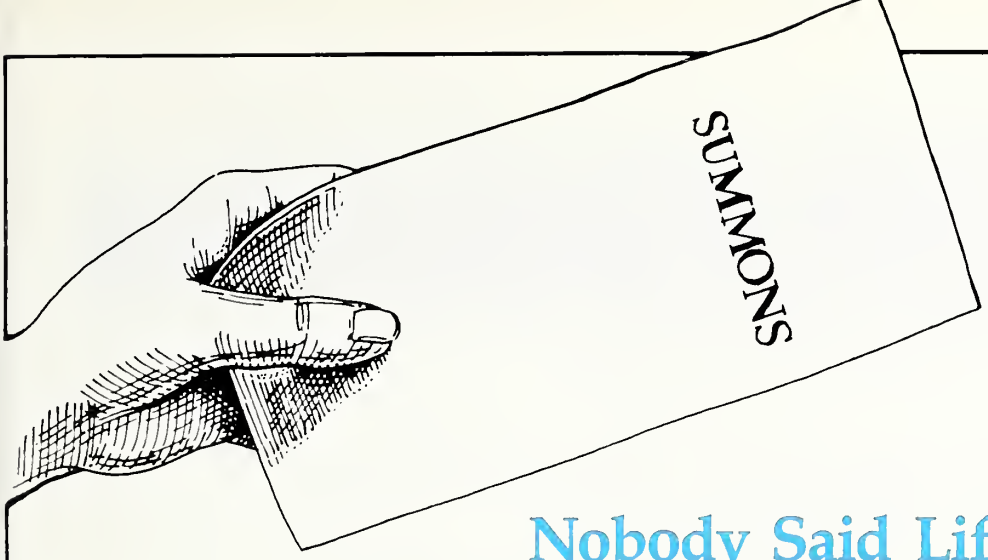


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The Viewbox

CONTRIBUTING EDITOR TERRENCE DEMOS, M.D., ASSOCIATE PROFESSOR OF RADIOLOGY,
DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was prepared by Kathleen A. Ward, M.D., department of radiology and Terrence C. Demos, M.D., associate professor of radiology, Loyola University Stritch School of Medicine.

This 36 year old woman has rapidly progressive aortic insufficiency (Fig. 1). She was healthy until age 33 when she was found to have bilateral deafness. Later she developed deformity of the nose (Fig. 2) and both external ears.

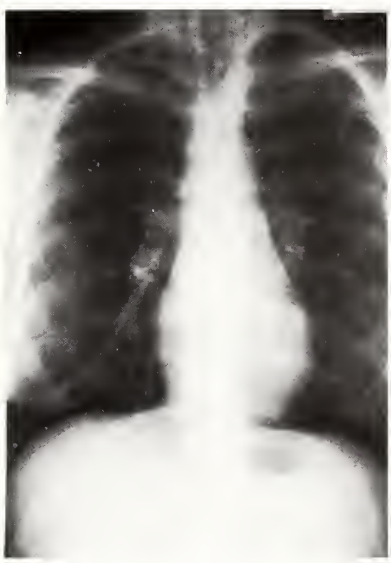


Figure 1A
Normal PA chest radiograph in 1980



Figure 1B
Cardiomegaly and evidence of congestive heart failure in 1982



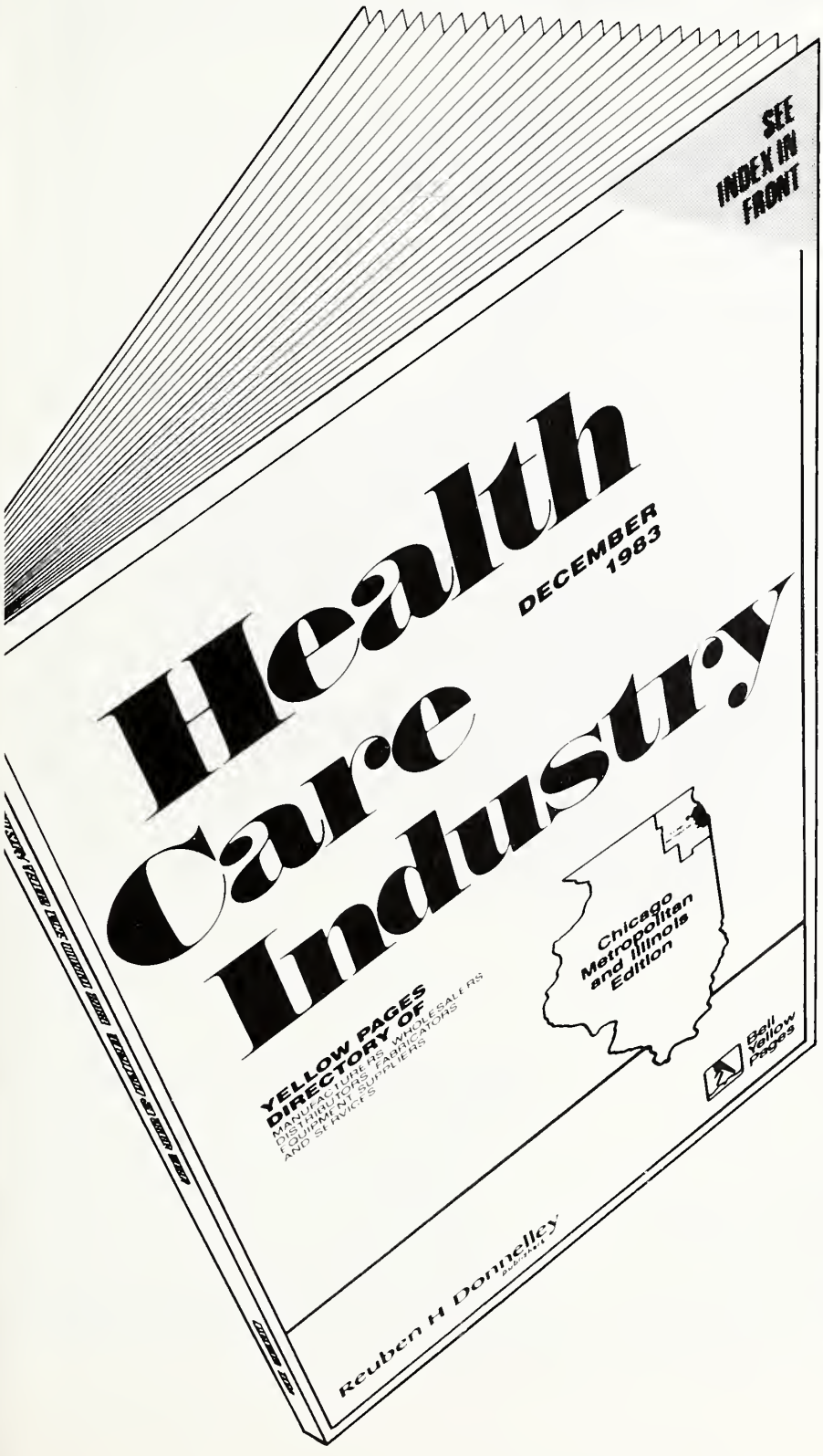
Figure 2
Deformed nose (Photo courtesy, Herbert Rubinstein, M.D.)

Your diagnosis?

(1) Marfan Syndrome
(2) Relapsing polychondritis
(3) Syphilitic aortitis
(4) Rheumatic valvular disease
(5) Ehlers-Danlos Syndrome

(Continued on page 56)

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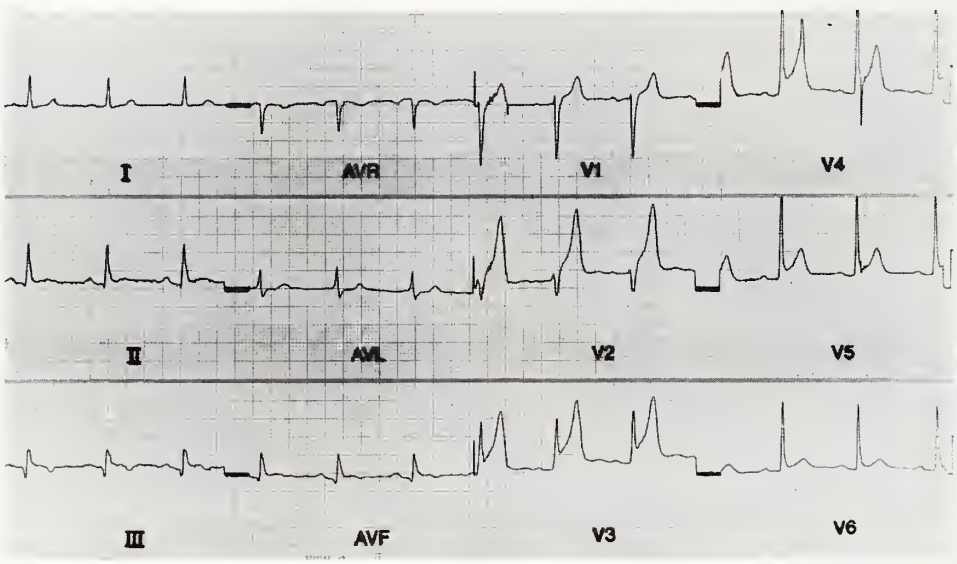
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Bell Yellow Pages

EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., John R. Tobin, M.S., M.D., Rolf M. Gunnar, M.S., M.D., and Patrick J. Scanlon, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a fifty-four year old man who was in good health except for an old myocardial infarction some 15 years earlier. He developed substernal chest pain and was hospitalized. New ECG changes were noted but no evidence of new myocardial infarction was found. A coronary angiogram demonstrated severe three vessel coronary disease. Aorta coronary bypass surgery was recommended and the patient was transferred to a cardiovascular surgical facility. While there, he developed severe substernal chest pain which did not respond to nitrates, propranolol and nifedipine. A loud atrial gallop was heard on examination of the heart. A twelve lead ECG was ordered and is shown.



Questions:

1. **The twelve lead ECG shows:**
 a. T waves compatible with hyperkalemia.
 b. Hyperacute T wave changes.
 c. ST elevation or a current of injury.
 d. Inferior wall myocardial infarction.
 e. All of the above.

2. **Management of this patient could include:**
 a. The intra-aortic ballon for counterpulsation.
 b. Anticoagulation.
 c. Emergency aorta coronary bypass surgery.
 d. Hemodynamic monitoring.
 e. All of the above.

(Continued on page 54)

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A Second Opinion

In July we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

As They Say In Baseball

Dear Editor:

When I read the *IMJ,* I look first to the President's page and then to any editorial comments that may be present. This is probably because I understand that content better than that of the scientific articles. I noted, then, the pleas from both your President and Editor for articles and reports from your members. This, I suppose, implies a lack of such scientific input from Illinois doctors, a conclusion that was initially surprising.

I am unfamiliar with the number and location of the medical schools, major hospitals, and the like in other states, but it appears to me that Illinois must have as many as most and more than some. Additionally, there must be a good many Illinois doctors who observe, study, and could report and write.

I said initially surprised, for on reflection and with transferrence to my own area of familiarity, I remembered the problems four or five years back with the TRIBUNE HERALD EXAMINER.

That's our local weekly newspaper. The name came about due to amalgamation and change in ownership. The WEEKLY TRIBUNE and the COUNTY HERALD were purchased by a newcomer in 1978. He wanted to add something of his own, and thus begot the TRIBUNE-HERALD-EXAMINER, or for my purpose, the THE.

At any rate, coming from the city, the new editor concentrated on hot news items from Chicago, St. Louis, Evansville, etc., and the best he could do was to have six-day old items which were of marginal interest to his readers. He kept wondering at the declining interest and circulation, and none of us here in town helped him because we weren't aware of any local important goingson. Then Chauncey Finley came home for the holidays from the University and brought with him his roommate who was what's called a "stringer" for a St. Louis newspaper. He began to poke around town and for several weeks' running that paper carried features on what was happening right here in Mt. Hawley.

Well, it doesn't take a backhoe to run over our citizens, or our editor either. Right off he realized that he had his own brand of journalism and publishing. He began to feature our activities and the citizens responded by writing up what was going on. Once a week now, we are all mighty pleased to read the THE and our stringer friend sends some of our stuff out to the St. Louis paper.

Seems like your Editor and your President have recognized the potential out among your members. Now, as they say in baseball, the ball is in their court. ◀

Sincerely,
Emerson Goodwins

Medical News

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Verapamil may be useful as a prophylactic medication for migraine headaches. Twelve patients with histories of migraine were evaluated in a double blind placebo and 80mgm verapamil QID schedule for three months. They were found to have a 49% lesser incidence of migraine attacks. Its effect is secondary to the calcium blocking action and resultant vasodilation. (Solomon, G., Steel, J., Spaccavento, L.: *JAMA* 250, 18:2500-2, 1983.)

A patient with a right coronary artery atherosclerotic lesion confirmed by serial angiography was treated with a lipid lowering regimen of diet and colestipol for two years and subsequently showed a regression of the atherosclerotic right coronary artery lesion. (Nash, D.: *Int. J. Cardiol.* 3:257-260, 1983)

Lancet reports on a multifactorial trial in heart disease prevention in 18,210 men between ages 40-59 employed in 24 factories. Risk factor advice was given, primarily by factory medical staffs. The study lasted six years and involved a randomized controlled trial of advice on cholesterol lowering diets, smoking cessation, weight control, exercise and treatment of hypertension. There was a 36% reduction in illness reports such as chest pains and angina. Changes in other risk factors was small. No changes were noted in incidence of coronary deaths and myocardial infarcts. (Rose, G., *et al.: Lancet* 1:1062-6, 1983).

Aspirin-Sulfinpyrazone was given to 203 patients treated postoperatively for total hip arthroplasty. When compared to placebo treated cases there was a 75% reduction in the incidence of deep vein thromboses in women, and a less statistically significant reduction of 32% in men. Deep vein thrombosis has in the past been variously reported between 30-70% in hip replacement cases with pulmonary embolism in approximately 10% of these cases. (Sautter, R., *et al.: JAMA* 250:19:2649-54, 1983)

Twenty four healthy individuals 65 years in age or over were placed on an exercise program three times weekly for 12 weeks to evaluate the effect of physical conditioning. The maximal workload on a bicycle ergometer improved, and exercise induced increases in the cardiac index and the end-diastolic-volume-index were greater after six weeks of exercise. Left ventricular ejection fraction and increase in the left ventricular end-systolic-volume index were unaltered. The left ventricular contractile performance in the elderly was thus not responsive to exercise training. (Schocken, D. *et al.: Am. J. Cardiol.* 52:359-64, 1983)

Lipsitz, *et al,* report on the effect of meals on blood pressure in elderly patients. In a young control group the systolic BP increased by 1mmHg in 35 minutes post-prandial. In the elderly with history of syncope the post-prandial systolic blood pressure dropped by 15+/−2 mmHg, and without histories of syncope the systolic BP dropped by 11+/−4mmHg. The authors thus suggest that a post-prandial reduction in systolic BP may contribute to increased incidences of falls, dizziness, and syncope. (Lipsitz, L., *et al.: New Engl. J. Med.* 309:81-3, 1983)

The safety and effectiveness of intraocular lenses have been monitored by the ophthalmic device section of the Food and Drug Administration since 1978. Seventeen different intraocular lenses produced by seven different manufacturers were evaluated in 45,543 patients. After a one year follow up, 84.8% continued to show visual acuity of 20/40 or better. The best results were obtained with the iridocapsular lense and the posterior chamber lense. Patients older than 80 years of age had poorer vision than the younger patients. Improved vision was not achieved in patients with preoperative corneal disease, glaucoma, iritis, iris neovascularization, diabetic retinopathy, previous retinal detachment, macular degeneration, and amblyopia. Complications occurred more frequently with the anterior-chamber and the iris-fixation lenses. (Stark, W. *et al: Ophthalmology* 90:311, 1983)

(Continued on page 36)

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*Additional NMR information on page 37

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IMJ
Illinois Medical Journal

Volume 165, No. 1, Jonuory 1984

The Value of Routine Small Bowel Radiography

By Gregory D. Moss, M.D. And James Fahrenbach, R.T./Chicago

Few significant positive abnormalities in routine small bowel examinations have been observed in our practice. The majority of small bowel requests are added to those for upper gastrointestinal examinations. Clinical information related to the small bowel is usually absent or somewhat nebulous. We have decided to evaluate the procedure and see if the examination was of benefit to the physician and patient. Similar efficacy studies for barium enemas[1,2] skull radiographs[3] and excretory urography[4] are well documented in the literature.

Ours is a 511 bed, comprehensive, general community hospital with medical school affiliation, offering residency training in internal medicine, surgery, pediatrics, obstetrics and gynecology and family practice.

The routine small bowel examination is obtained following the upper GI series with an additional 500-600ml of barium. Serial 14 × 17 inch radiographs are obtained at 30 minute intervals or as directed by the radiologist monitoring the examination. The radiologist surveys the abdomen fluoroscopically when barium has reached the ascending colon, and obtains spot films of the terminal ileum and ileocecal valve. If any abnormality has been noted on the earlier radiographs, spot films of this area may be obtained as well. In some cases, a small bowel examination is performed which eliminates fluoroscopy and overhead films of the stomach. The average radiation dose at skin surface is approximately 244mR per exposure.

James S. Fahrenbach, R.T., is the administrative director of the department of radiology, St. Joseph Hospital, Chicago. Mr. Fahrenbach is a former quality control technologist. He is a member of the American Registry of Radiologic Technologists.

Gregory D. Moss, M.D., is a board certified radiologist affiliated with St. Joseph Hospital in Chicago. A clinical assistant professor at the Chicago Medical School, Dr. Moss is the vice chairman of the department of radiology at St. Joseph.

Methods

A prospective study involving all small bowel examinations during a five month period was performed. Following the standard examination, the written radiographic report was sent to the referring physician along with a questionnaire asking whether the reported result: (a) confirmed the clinical impression; (b) influenced patient management and (c) lead to further diagnostic studies. The results of this survey were collected along with copies of the Xray report and Xray requisition as filled out by the referring physician or house staff member. No attempt to clarify requests or indications for the examination was made. Most requests were nonspecific as related to small bowel disease.

The results were tabulated and all abnormal examinations were reviewed. The stated clinical reasons for suspecting small bowel disease as given on the requisition were documented. We also tabulated the pattern of referral based on the specialty or subspecialty of the referring physician.

Results

A total of 124 examinations were performed. Completed questionnaires were received on 49 patients (39.5%). Six of these were reported as abnormal (12%). A total of 43 examinations were

Table 1						
	Confirm clinical impression?		Influence patient management?		Further studies?	
	Yes	No	Yes	No	Yes	No
Abnormal 6	6	—	6	—	3	3
Normal 43	24	19	24	19	15	28

normal (88%). Seventy five questionnaires were not received. Two of these were abnormal studies (2.6%). Three of the six abnormal studies for which questionnaires were received had known regional ileitis and two had strong clinical suspicion for incomplete small bowel obstruction. The last patient had a very rapid transit time, an equivocal abnormal finding. Three of the abnormal examinations were scheduled as small bowel studies only; further evidence of strong clinical suspicion for small bowel disease. Five of the normal examinations were ordered as small bowel only examinations. The results of the questionnaire are shown on Table 1.

The pattern of referral was also tabulated. Of the six abnormal examinations, three were requested by family practice physicians, two by gastroenterologists, and one by a general internist. Of the 43 normal examinations, 27 were requested by general internists, nine by family practioners, six by gastroenterologists, and one by a general surgeon. No definite pattern could be inferred.

The clinical reason for ordering the small bowel examination as given on the radiology request form was tabulated for all studies in which questionnaires were received. In the six abnormal studies, clinical histories were considered specific for small bowel disease. In the 43 negative studies clinical histories were vague, ranging from nonspecific abdominal pain, possible GI bleeding or not specifically related to the small bowel tract.

Discussion

Quality assurance in diagnostic radiology concerns three goals.[5] These are: (1) assurance that the appropriate study is ordered to achieve the intended diagnostic purpose; (2) assurance that the maximum diagnostic potential is achieved with minimal radiation exposure and (3) assurance that the study is accurately interpreted. The radiologist should be accountable for the appropriateness of studies performed in the radiology department. Efficacy or usefulness is a measure of the impact of radiographic information on a three level decision hierarchy. The clinician should consider whether and how the information (1) affects his or her decision in relation to the patient or changes his thinking; (2) effects the choice of treatment; and (3) effects long range patient outcome.

It was our contention prior to this study that the indiscriminate or incidental small bowel examination has a very low yield of positive findings. The exact impact of the procedure on patient management was to be evaluated by asking the referring physician responsible for patient management. The results of our admittedly small sample indicate that during the period of our study the abnormal examination was anticipated and the examination influenced patient management. The abnormal study led to further diagnostic studies in 50% of cases.

In the negative studies, there were less specific clinical indications referrable to small bowel abnormalities, as well as more ambiguity in the referring physician's perception of the value of the examination. In 55% of cases, the negative examination was anticipated and influenced patient therapy. Our results are similar to two recently published reports as to the value of the efficacy of small bowel examinations.[6,7] We were unable to distinguish true and false negative studies. However, one patient with the clinical presentation of GI bleeding had two normal small bowel examinations. Gastroscopy and colonoscopy were also normal. A jejunal leiomyoma was subsequently demonstrated by angiography.

The routine small bowel study is insensitive in evaluation of certain pathologic disorders.[7] The small bowel follow through examination is limited because the entire small bowel is often not completely filled, and is often very difficult to evaluate. Rabe, *et al.*, have published a list of indications considered to be of high yield for positive results. The indications for small bowel studies are poorly defined. More sensitive examinations may be indicated. These might include enteroclysis, technetium 99 labeled RBC scanning, angiography or small bowel biopsy.[8]

Enteroclysis, or a small bowel enema, is performed by introducing barium directly into the small bowel by a tube placed into the duodenum. This is not a routine procedure. This examination should follow the small bowel follow-through exam when the diagnosis is unclear, or when there is a strong clinical suspicion for pathology. Although no prospective study has been done, available data suggest that a small bowel enema is more accurate than the follow-through exam.[7]

The anticipated abnormal study is effective in terms of patient radiation and financial costs. The

results are equivocal in less specific clinical instances and the low yield of positive findings is not cost effective.

It is apparent that this examination may be a routine procedure rather than the result of discriminating clinical judgment. In a teaching institution, the test may be ordered by inexperienced physicians in training with unrefined decision making skills. There may be a failure to understand and use radiographic examinations properly, and there may be a lack of knowledge concerning cost, in both monetary and patient radiation terms.

In some instances, patients may be satisfied if multiple radiographic examinations are included in their care. The patient and physician may be reassured by normal findings. Some physicians, when faced with a confusing clinical picture, may be reassured by negative findings to narrow their differential diagnosis. Due to the low sensitivity of the examination, these may be false assurances.

Conclusion

The small bowel series could be a valuable procedure if performed when clinical suspicion for small bowel disease is high. If there is a low suspicion for small bowel disease, the procedure is often of limited value and is not cost effective.

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Intracystic Carcinoma of the Breast

By Bak M. Lee, M.D./Bloomington

Intracystic carcinoma is a very rare type of breast cancer. It is seen in elderly women, and commonly associated with hypertension, obesity or diabetes mellitus. It usually presents as a large cystic breast lesion. Axillary lymph mode metastasis is far less common than infiltrating duct carcinoma of the breast. Two cases of intracystic carcinoma are observed. Clinical findings and management are discussed.

Review of literature reveals only a few studies of intracystic carcinoma of the breast. Gatchell, *et al.*, initiated his study after encountering a carcinoma of breast arising from the wall of a "blue-domed" cyst.[1] In a 35 year study, (1920-1954) his cases showed papillary growth, a clinical picture suggestive of a benign condition of the breast and good prognosis in general. Czernobilsky's study revealed that intracystic carcinoma of the breast is different from secondary cystic degeneration of a previously noncystic breast carcinoma and from carcinomatous invasion of a pre-existing benign breast cyst.[2] Intracystic carcinoma presents as a large, solitary hemorrhagic cyst surrounded by a fibrous wall with papillary adenocarcinoma in the inner surface of the cyst and the absence of extensive tumor involvement of the surrounding tissue.

Case Reports

Case 1: This 78-year-old Caucasian woman was admitted to the hospital because of painful enlargement of her right breast. She informed her physician that the breast change had been noticed during several weeks prior to the admission. Patient was Grade II, para II. She was on medical treatment for osteoarthritis and moderate hypertension. She also had a problem with weight gain and mild diabetes. Physical examination revealed a large cystic mass occupying the right breast. The left breast was unremarkable. Blood count, urine and serum chemistry were normal. Xeromammogram revealed a large cystic mass with a portion of solid mass adjacent to the cyst (Figure 1). The aspiration of cystic fluid showed degenerating hemorrhagic fluid without any recognizable epithelial cell element. The excision of the cystic mass revealed a large cyst with hemorrhagic degenerating material in the lumen (Figure 2). The inner surface was slightly

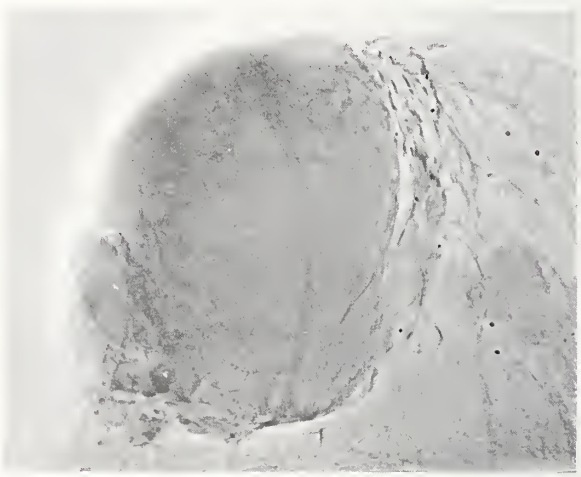


Figure 1
Xeromammogram showing a large mass in outer half of the right breast with smaller nodular densities on the border. Also, an additional mass is seen medially.

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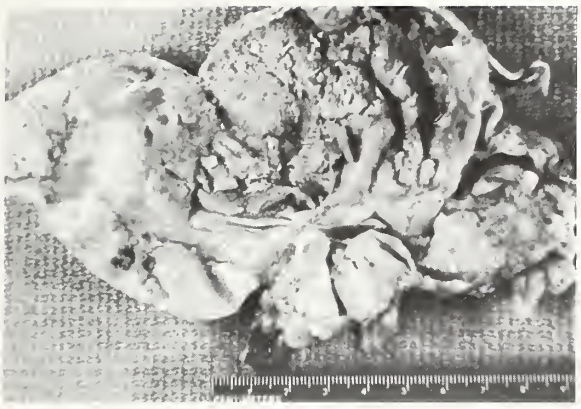


Figure 2
Macroscopic examination of the cystic mass showing hemorrhagic degenerating material in the lumen and irregular induration in the cyst wall.

irregular. There was a solid mass adjacent to the cyst. The section of cystic wall revealed papillary carcinoma of breast (Figures 3A & 3B). The section of the solid mass revealed infiltrating papillary carcinoma of the breast. Surgery with modified radical mastectomy was done in which there was an additional focal area of infiltrating duct carcinoma in the residual portion of breast. The axillary lymph nodes showed no evidence of malignant neoplastic change. No additional treatment was given. The patient is well without any evidence of metastasis at the present, three months after the surgery.

Case 2: This 78-year-old Caucasian woman was admitted to the hospital because of an enlarged right breast with mild tenderness. She informed her physician that her breast change had started a few

Figure 3A and 3B
Microscopic examination 3A (low power magnification) and 3B (high power magnification) showing a well differentiated papillary carcinoma in the cyst wall.

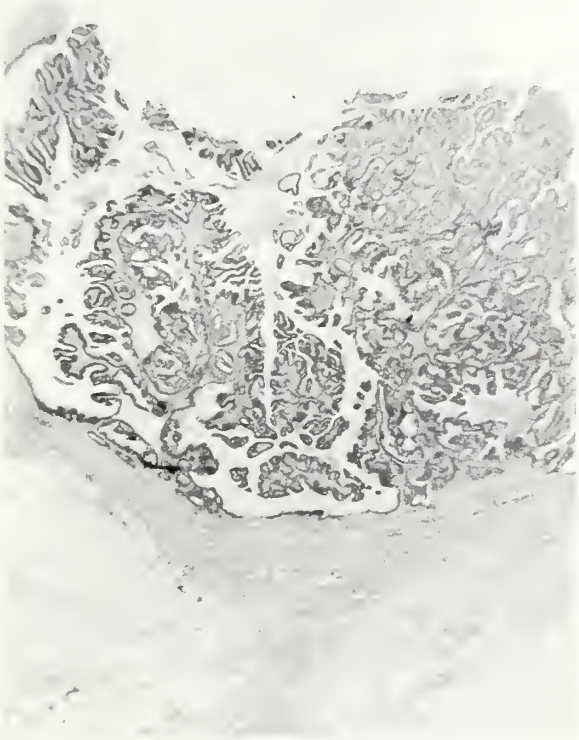


Figure 3A

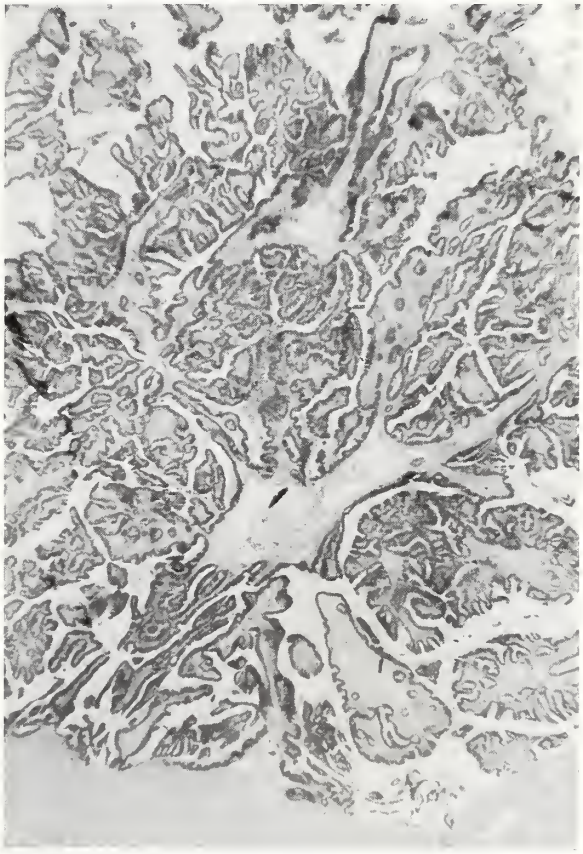


Figure 3B

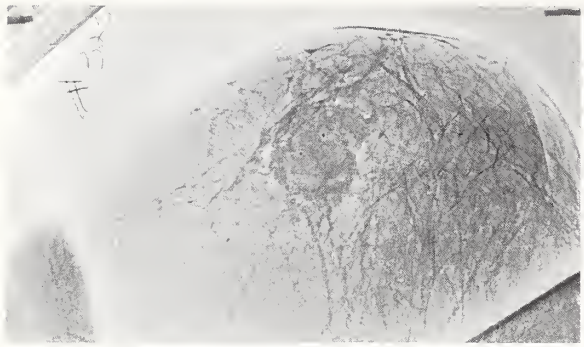


Figure 4
Xeromammogram showing a large mass in midportion of the right breast with relatively smooth margin. However, there is local irregular margin with smaller nodules.

weeks prior to admission. She was Grade III, para III. She had had cataract surgery several years before and reported treatment for moderate hypertension. She had no evidence of diabetes.

Physical examination revealed a large cystic mass in her right breast. The left breast showed a soft, ill-defined mass. Blood count, urine study and serum chemistry were nonspecific. Xeromammogram revealed a large cystic mass with a portion of solid mass adjacent to the cyst in her right breast (Figure 4) and an ill-defined mass in her left breast. Excision of the mass in her left breast revealed a lipoma. The large cystic mass in her right breast had hemorrhagic, degenerating, partly fluid material in the lumen, a fibrotic cyst wall and a small soft mass adjacent to the cyst. Section of cyst wall revealed papillary carcinoma. Section of the solid mass revealed infiltrating carcinoma. Modified radical mastectomy for the right breast was performed. The residual right breast portion revealed an additional area of intraductal carcinoma microscopically. Axillary lymph nodes showed no evidence of metastasis. The patient is well without any evidence of metastasis at present, one year after the surgery.

Discussion

Intracystic carcinoma of the breast is very rare. The incidence of intracystic carcinoma in previous studies was 0.5% in review of 9,000 breast carcinoma[1] and 0.56% in review of 2,500 breast carcinoma.[2] The lesion occurs in elderly women. The mean age for the intracystic carcinoma is 67 years, as compared to 54.5 years for all breast carcinoma.[2,3] Also, the lesion occurs in women usually having problems with hypertension, obesity and/or diabetes mellitus.[1-3] In present cases, Case 1 had hypertension, obesity and diabetes mellitus and Case 2 had hypertension. The lesions were equally distributed between left and right breasts.[3] Gatchell, *et al.*, revealed that 90% of the cases came for examination because of the discovery of a mass in the breast[1] and Czernobilsky revealed that the most common complaint at the time of admission was an increase in the size of the pre-existing breast mass.[2] The size of the cyst was recorded from 2.5cm to "immense."[3] There were cases involving the whole breast by the cystic mass.[3] Xeromammogram of the breast showed a large cystic area with a local area of soft mass suggesting malignant change as seen in the present cases. Aspiration cytology yielded hypocellular specimen diluted by hemorrhagic fluid. The presence of significant hemorrhagic fluid within the aspirated material should provoke suspicion of malignancy.[4] One should obtain the aspiration from the solid mass area adjacent to the cyst in order to see malignant neoplastic cells by aspiration cytology. Fine needle aspiration and pneumocystogram appears very helpful for the diagnosis of cystic mass of breast.[5]

Excision of the intracystic carcinoma of the breast revealed a very typical macroscopical finding with a usually solitary large hemorrhagic cyst surrounded by a fibrous wall, an irregular inner surface, hemorrhagic degenerating material in the cystic lumen and a local solid indurated nodule in the surrounding area of the cyst wall. The microscopical examination of the cyst wall showed mostly papillary carcinoma and the local solid indurated nodule showed infiltrating carcinoma. The intracystic carcinoma behaves less aggressively than one would expect considering the clinical presentation with a very large breast mass.[1-3] Lymph node metastasis of intracystic carcinoma is far less common that noncystic carcinoma of the breast.[4] It is felt that intracystic carcinoma of the breast is almost always a carcinoma arising from a long-standing intraductal papilloma, but the carcinoma so arising is most often a non-papillary ductal carcinoma. The treatment should be the same as noncystic carcinoma of the breast. ◀

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Evaluation of Children With Developmental Disabilities

By Maurice Solodky, Ph.D.,
Marjorie Thorsness, M.A. and
Rabi F. Sulayman, M.D./Oak Lawn

Traditional physician training and school evaluation have proven inadequate to meet the needs of children with developmental problems. Utilizing the expertise of a hospital based team of professionals and the interdisciplinary approach, we evaluated 194 patients, nine months to 25 years of age, with developmental dysfunction. A total of 75% had previous evaluations. A previously unsuspected medical problem (such as cerebral palsy, psychosis, endocrine and metabolic disorders and CNS disease) was identified in 12. Four patients had abnormal findings when examined by a neurologist, but 50% of all children were demonstrated to have soft neurological signs by the occupational therapist. A total of 135 patients had a previously undiagnosed problem or the implementation and design of their therapy program was not considered effective. Improvement was reported in 90% and intervention with remedial education emerged as the central component of care provided. This suggests that accurate assessments and effective intervention for children with developmental problems can best be performed using the interdisciplinary team approach and appropriate physician input. Evaluations in which the services of different professionals are sought separately are costly and lack the necessary interaction for accurate diagnosis.

Failure of an individual to conform to the expected pattern of human development may result from a variety of causes. These include genetic disorders, psycho-social maladaptation, sensory impairment, central nervous system dysfunction or immaturity, and other disorders.[1] One or more of the elements of developmental function may be effected[2] and the specific pattern of deficiency expresses itself in a broad range of clinical manifestation and severity. These children usually present complex and often perplexing diagnostic challenges which are frustrating to both parents and physicians. This explains the array of labels proposed to identify children with these handicaps: hyperactivity, minimal brain dysfunction, learning disability and developmental dyslexia.

At present, there is little doubt that developmental dysfunctions, expressed as language disorders, behavioral disorganizations, learning problems, attentional problems with or without hyperactivity and cognitive sensory and motor handicaps, are recognized as appropriate pediatric concerns.[3] There is also little doubt that the traditional training of the pediatrician and the diagnostic evaluations performed solely through the school systems have proven to be inadequate in meeting the needs of children with developmental disabilities.[3-4] In fact, it has been shown that the diagnosis is of such

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Table 1
Members of the Developmental Evaluation Team

1. Pediatrician
2. Pediatric Neurologist
3. Child and Adolescent Psychiatrist
4. Clinical Psychologist
5. Neuro-Psychologist
6. Occupational Therapist
7. Speech & Language Pathologist
8. Educational Specialist
9. Social Workers
10. Pediatric Nurses

Table 2
Summary of the Utilized Diagnostic Modalities

1. Psycho-social history and parent interview.
2. Medical history.
3. Physical examination including assessment of vision, hearing and CNS function.
4. Tests for developmental level and function in the areas of fine motor, gross motor, adaptive (cognitive) reflexive maturation, oral-motor, oculo-motor, personal-social skills, visual motor integration, visual perceptional development and neurological integration.
5. Tests for hearing sensitivity, language comprehension, language formulation and speech production.
6. Tests for intelligence, brain damage, personality, emotional and behavioral problems.
7. Tests to determine verbal and non-verbal cognitive processing skills of auditory receptive and expressive language; intrasensory visual skills; intersensory processing; written language; mathematics; non-verbal perception, symbolization and conceptualization.
8. Formal assessment and informal observational data for attentional functioning.

complexity that close cooperation between school personnel and the medical specialties is required.[4] To achieve appropriate diagnosis, the multidisciplinary approach has been recommended[3-4] and some states, such as Massachusetts, passed a special act to specify the process (Bartely-Daly Act of 1972—Chapter 766).

The multidisciplinary approach is not a new pattern for child study. Almost twenty years ago, the "University Affiliated Facilities" program was created to provide training in the interdisciplinary techniques of child assessment and therapy. There are today a large network of such centers located in major university medical centers working with such children. Substantial literature has emerged from this interdisciplinary movement.[5-7] Many thousands of children, however, have no easy access to those centers and have to be evaluated "locally." Many of those who are evaluated at such centers continue to have significant difficulties requiring further evaluations and constant modification of their therapy programs.

In 1977, our hospital organized a special unit for evaluation of children with developmental problems. The unit was staffed by professionals representing all the necessary disciplines for the accurate assessment of these children. The unit was organized around the interdisciplinary diagnostic approach where the final diagnosis and treatment plan are a consequence of that direct interaction of consultation and cooperation among team members.

The purpose of this article is to further describe this program and compare the effectiveness, reliability and impact of the most prevalent methods in evaluation and therapy of children with developmental dysfunction.

The Evaluation Team—Structure and Operation

Our team is composed of professionals from various disciplines who are able to assess all the modalities which manifest developmental dysfunction. The various disciplines appear in Table 1. To minimize organization and evaluation costs, the unit utilizes services of professionals already available in the hospital.

A uniform approach with one predetermined battery of tests was quickly found to be unsatisfactory due to the diverse nature of the problems encountered. Thus, the unit utilizes an initial procedure of discussing each child in a group staffing before any testing is done. The methods of approach and the administered tests are determined at this time and are tailored to each child. To facilitate this procedure, it is essential that accurate psycho-social and medical histories are obtained prior to the staffing. A social worker obtains these histories through an intake interview. They provide information regarding the reason for referral, previous evaluations and therapy, family dynamics and medical, social, behavioral and academic status. After the evaluation plan and approach have been formulated, the pediatric nurse develops the child's individual testing schedule. Within a two-day period, the child is scheduled for an appropriate evaluation and each evaluator is scheduled for an additional parent interview. As stated, the diagnostic tests are chosen on the basis of presenting complaints. Tables 2 and 3 summarize the diagnostic modalities which have been utilized frequently.

Table 3
Laboratory Diagnostic Modalities

First Stage

1. Complete blood count.
2. Urinalysis
3. Urinalysis for reducing substances, phenyl pyruvic acid and amino acids.
4. Serum chemistry for blood sugar, urea nitrogen, amino acid screen, calcium, phosphorous, magnesium and serum trace metals.
5. Thyroid function studies.
6. Bone age.
7. Skull x-rays.
8. Electroencephalogram.
9. Brain scans.
10. Chromosome studies.

Second Stage (Only if clinically justified)

1. Specific tests for failure to thrive, growth disorders and mental retardation.
2. Serum enzymes.
3. Antibody titers and serology.
4. Immunoglobulins.
5. Inclusion bodies.
6. Metachromasia.

Table 4
Major Reasons for Referral

Complaint	Percent of Total
Academic Problems	17%
Behavioral Problems	36%
Academic/Behavior	18%
Speech Problems	11%
Deficit in Attention	7%
Developmental Delay	11%
Total	100%

Table 5
Summary of Diagnostic Categories of 194 Evaluated Patients

Diagnosis	Percent of Total
Learning Disability	24%
Attention Deficit Disorder With Learning Disability	22%
Attention Deficit Disorder Without Learning Disability	5%
Schizophrenia	2%
Behavior Disorder	25%
Psycho-Motor Retardation	9%
Cerebral Palsy	3%
Primary Language Disorder	3%
Failure to Thrive	1%
Normal	2%
Others	4%

Immediately following evaluation, all team members meet to staff the case. The team members discuss their impressions and the results of their evaluations in order to determine the diagnosis and an appropriate set of recommendations. Directly following this staffing, all team members are involved in the parent conference. Each professional explains the test results and answers questions raised by the parents. The moderator then summarizes the diagnostic impressions and recommendations for treatment. A typewritten report is prepared and copies are mailed to the parents, referring physicians and appropriate agencies involved with the child. Subsequent staffing sessions with schools, health care facilities and parents are held upon request.

Materials and Methods

Records of all children referred to the developmental evaluation unit were reviewed. This included an analysis of complaints, psycho-social history and interview, medical history, physical findings, results of the evaluations, laboratory procedures utilized and recommendations. To assess accuracy and effectiveness of diagnosis and recommendations, the parents were interviewed three, six and nine months after the evaluation and progress reports were obtained from schools, agencies and primary physicians. Our results were compared, whenever possible, to the results obtained by school psychologists, pediatricians or neurologists prior to our evaluation.

Results

A total of 194 patients, ranging in age from nine months to 25 years, were evaluated at the center between January, 1978 and July, 1980. There were 138 males (71%) and 56 females (29%). The average age at the time of evaluation was 7.9 years for boys and 7.0 years for girls. The majority of children (58%) were referred by physicians. A total of 22% were referred by school systems, 7% by other health care agencies and 13% came from other sources. Table 4 summarizes the reasons for referral. As can be seen, 71% were referred with the

Table 6
List of Medical Problems Which Were Responsible for the Manifestations of Referred Patients

Reason for Referral	Diagnosis	No. of Patients
Clumsy, Poor School Performance	Cerebral Palsy	3
Attention Deficit/Possible Seizures	Schizophrenia	2
Slow, Poor School Performance	Pseudo Pseudohypoparathyroidism	1
Developmental Delay	Cystic Fibrosis	1
Behavior Problem	Lead Encephalopathy	1
Behavior Problem, Poor School Performance	Brain Tumor	1
Poor School Performance	Williams Syndrome	1
Poor School Performance/Behavior Problem	Lawrence-Moon-Biedl Syndrome	1
Behavior Problem	Hypoglycemia	1
Total		12

complaint of academic and/or behavioral problems.

Seventy-five percent of all the patients had one or more previous evaluations. The majority had evaluations performed by school psychologists, although many had separate evaluations by neurologists, psychiatrists, psychologists and optometrists. Only 4% of the children had a previous evaluation at a major medical center by a multidisciplinary team.

All patients who had been previously evaluated were placed on some form of therapy as a result of the evaluation. Special educational placement was the most prevalent form of intervention followed by counseling and speech therapy. Eight percent of the patients were enrolled in special therapy sessions to improve ocular muscle control. Thirty percent of the children were on drug therapy and 38% on an antihyperactive diet prior to our evaluation.

Tables 5 and 6 summarize the team's diagnostic impressions of the population evaluated. As can be seen, 46% had evidence of a learning disability. Half of those children were found to have soft neurological signs when evaluated by an occupational therapist. A neurological examination performed by a neurologist on 32 of those patients found that only four were grossly abnormal. Diagnoses of the patients listed in Table 6 were not suspected prior to their referral.

Table 7 summarizes the recommendations made by the various professionals following the interdisciplinary evaluation. Almost half of the children evaluated required a specially designed, individualized program of therapy and simultaneous involvement of a special education instructor, an occupational therapist, a psychologist and a speech therapist.

Two-thirds of the patients were advised to obtain some laboratory tests. An electroencephalogram was performed in 29 of these patients but was abnormal in only three. Drug therapy was continued in 52 patients and the "antihyperactive diet" in 23. The decision to continue those two modalities of therapy was based upon the impression of parents and teachers that they have helped in the past. Monitoring those children subsequent to the evaluation revealed that 36 (70%) of those on drug therapy and four (2%) of those on the diet showed improvement in behavior and attention that could actually be attributed directly to the drugs and/or the diet.

The impressions developed after the evaluations, when compared to those from previous evaluations, were similar in only 30% of the patients. Of those previously evaluated, 70% were found to have either a previously undiagnosed problem or an ineffective therapy program.

The majority of families (90%) contacted for a follow up progress report indicated that they felt the evaluation was satisfactory. Eight percent did not report satisfaction and success in following through with the recommendations for specific therapies. Six families reported that the school system did not accept the results of the evaluation and had the child re-evaluated by the school; these parents reported that no new information was obtained during the re-evaluation.

Table 7
Summary of the Recommendations

Educational (Class Placement/Educational Program)	95%
Psychological/Psychiatric Counseling & Follow Up	76%
Speech/Language Therapy	38%
Occupational Therapy/Stimulation Program	48%
Laboratory Tests (Including Electroencephalograms)	65%
Drug Therapy	30%
Antihyperactive Diet	12%

Discussion

While the exact incidence of developmental problems is not known, they are not uncommon.[1] These problems become obvious when the children start school, although most may have clinical manifestations earlier than that.[8-11] The fact that these children are not recognized earlier, when intervention methods are most effective, is directly related to the poor understanding of the complex nature of these problems. Routine psychological testing as performed by school psychologists, and physical examinations as performed by physicians are not enough to provide the child with an adequate therapeutic program, irrespective of the professional's level of training, proficiency or qualifications.

A multidisciplinary approach is helpful.[4] However, a distinction must be made between a multidisciplinary and an interdisciplinary approach in evaluation of developmental disabilities. A multidisciplinary group is often a variety of professionals working in the same facility who are responsible only for their own professional input. An interdisciplinary team is a group of professionals who communicate their findings and collectively arrive at diagnoses and recommendations. Prerequisites for an interdisciplinary team include a basic knowledge of each discipline, flexibility and the ability to listen.

Most researchers report an incidence of developmental problems which is much higher in boys than in girls, with ratios of up to 7:1 reported.[12] We found the ratio to be about 2:1. The fact that many of these children did need several evaluations does not only reflect the complex nature of these problems but also the inadequacy of the single-discipline evaluation and therapy program.

The so-called soft neurological signs such as eye-hand preference, balance stereognosis, graphasthesia, choreoathetosis and diadokokinesia were present in 50% of the children with learning disabilities. Their presence, however, should be interpreted cautiously[13] and does not necessarily mean that the child will require an extensive neurological work up.

The electroencephalogram was found to be helpful only in a few children, especially those with consistant neurological deficits or physical abnormalities. The majority of children with developmental dysfunctions, however, do not have gross abnormalities and the EEG should not be performed.[14] These findings are compatible with previous reports[15] where a very low incidence of paroxysmal abnormalities and seizure potentials were found when patients with convulsive disorders, mental retardation and gross neurological deficits were excluded. Appropriate input from physicians and the judicious use of laboratory procedures continue to be extremely important if one is to exclude potentially treatable conditions.

The failure of therapy programs initiated prior to our evaluation may have been due to a number of factors other than inadequate evaluations. Those factors include the obvious absence of physician input, the absence of communication and interaction between the various professionals involved in therapy of the child, the exclusion of the parents as partners in the therapeutic programs and the indiscriminate grouping of children with different problems into predesigned therapeutic programs plagued by policies dictated by economic factors.[16] Other contributory factors included (1) the misconception that blind use and reliance on drug therapy is enough to achieve a quick "cure;"[17-18] (2) absence of professionals to monitor educational recommendations; (3) lack of appropriate re-evaluation to monitor progress and (4) use of unproven and non-controlled methods of intervention, such as ocular exercises.[19-25]

The age range observed in the children demonstrates again that developmental disabilities are not transient and warrant concern akin to that provided for any other pediatric disease.[25] Parents require support and counseling. Remedial education for the children continues to be a crucial element in the success of a complete treatment program.

Summary

In conclusion, it appears that the evaluation of children with developmental problems can be carried out most effectively, efficiently and successfully through an interdisciplinary approach. Not only is input of professionals from various disciplines required for an accurate assessment, but utility and clarity is improved when this input is simultaneously presented, discussed and compared with results from other professionals involved.

Evaluation and therapy programs that rely on only one or two specialists should be encouraged to

utilize interdisciplinary teams. An interdisciplinary team approach need not be expensive or time-consuming and allows for the individualization of evaluation and therapy programs for each child.

Referral Sources

A number of similar programs accept referrals from private physicians. Two sources of referral listings are known to the authors and recommended. The CAEYC-Infant/Toddler Program Directory is published by the Chicago Association for the Education of Young Children, 410 S. Michigan Ave., Suite 401, Chicago 60605; (312-427-5399). This directory is prepared by the CAEYC Commission on Infants and Toddlers.

A listing is also available from the Coordinating Council for Handicapped Children. The Directory of Services for Handicapped Children and Adults may be obtained by writing them at 407 S. Dearborn St., Chicago 60605; (312-939-3513).

References

A complete list of references for "Evaluation of Children With Developmental Disabilities," may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago 60603. ◂

Medical News

(Continued from page 23)

Fifty geriatric patients with undiagnosed gait disorders received a medical work-up. Cervical myelopathy was found in 16%, multiple sensory disturbances were found in 18% and 16% had an idiopathic senile gait disorder (no other cause found). Only 24% of patients had conditions amenable to therapy. These 50 patients did, however, exhibit ventricular enlargements compared with age matched controls. (Sudarsky, L., Ronthal, M.: *Arch Neurol.* 40:740-3, 1983)

Diastolic blood pressures of 90-104mmHg have been considered to be mild hypertension. A great deal of debate has centered on whether or not these patients should receive hypertensive treatment. Seventy percent of the population (or 40 million people) fall in this category. The World Health Organization bulletin recommends lowering the diastolic blood pressure to less than 90mmHg. A recent editorial in the *Annals of Internal Medicine* states that published reports to date are inconclusive to warrant treatment for all patients. Individual therapeutic stategies and risk considerations may avoid needless drug treatments. (Ram, C.: *Ann. Intern. Med.* 99:403-5, 1983)

Tuberculosis should again be included in the differential diagnosis of elderly patients presenting with (1) symptoms referrable to the pleuropulmonary system, (2) unexplained fever, (3) anorexia, (4) weight loss, (5) change in behavior, (6) organ dysfunction and (7) abnormal laboratory findings without cause. The skin tests most often are not reliable. Multiple sputum samples or supplemental invasive means may be required. Treatments at present are isoniazid and rifampin with precautions for hepatitis occurrence. Alcohol users have four times the risk of nonalcohol users. (Nagami, P., Yoshikawa, T.: *J. Am. Geriatr. Soc.* 31:356-63, 1983)

Intracoronary streptokinase or placebo were administered to 40 patients within six hours of onset of an acute myocardial infarct. Patients selected were those in whom the coronary artery to the infarct zone was totally occluded. Reperfusion was established in 60% of patients receiving a total of 250,000IU, and in 10% of those receiving the placebo. The angiographic ejection fraction, LV end-diastolic pressures, regional wall motion, and serial radionuclide ejection fractions did not differ between the streptokinase and the placebo groups. The authors suggest that intracoronary fibrinolysis should be considered in those patients where diagnosis is established immediately and treatment can commence immediately. (Khaja, F., *et al.: N. Engl. J. Med.* 308:1305-11, 1983.)

Twenty two long term diabetic patients were followed for up to four months to observe changes in peripheral neurologic symptoms and signs with improved control of their diabetes. This improved diabetic control was followed by means of reduced levels of hemoglobin A/1. Improvements were noted in conduction velocity studies, particularly in the upper rather than in the lower extremities. Losses in vibratory perception remained unchanged. Temperature perception improved in the legs but did not change in the upper extremities. (Agardh, C. *et al: Acta. Med. Scand.* 213:283-7, 1983)

An analysis of colorectal carcinomas on 2,298 patients between January 1961 and December 1979 revealed rectal locations in 38.8% in the first decade and 33.8% in the second decade. The sigmoid location was seen in 27.4% in the '60s, and 24.9% in the '70s; transverse colon was seen 13.5% in the '60s and 11.9% in the '70s and right sided colon was the site of 14.4% in the '60s and 22.2% in the '70s. The later two are not reached by the flexible sigmoidoscope and require a barium pneumocolon examination for diagnosis. (Maglinte, D. *et al.: Radiology* 147:669-72, 1983). ◂

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Case Reports

Single Renal Artery Aneurysm Measuring 10cm. in Diameter

By Lisa S. Radwine, M.D. and Robert E. Winders, M.D./Springfield

This is a single case history of a 72 year old man with a huge calcified renal artery aneurysm measuring 9 × 10cm. in diameter which was discovered incidentally on an intravenous pyelogram. A vague history of blunt trauma to the left flank during his teenage years was elicited. Arteriography was done for further evaluation. Prior to surgery, a balloon catheter was placed in the left renal artery to occlude blood flow and provide the surgeon with a dry field.

A 72 year old white male was admitted for urological diagnostic workup. When seen for the first time by the urologist, he reported several attacks of gross totally painless hematuria nine days prior to his visit. He had been seen in an emergency room, was thought to have infection and was placed on Septra DS® every 12 hours. Since he had absolutely no urgent dysuria, frequency, chills, or fever with his quasi-infection and since his urine specimen at that time was negative except for some microscopic hematuria, the patient was investigated urologically by an IVP and cystoscopic examination. He was found to have grade II enlarged prostate that was benign, but was significant, causing outlet obstruction.

An intravenous pyelogram (IVP) revealed a large calcified mass attached to the medial aspect of the upper portion of the left kidney. Diagnostic considerations at this time were calcified hypernephroma, renal cyst, adrenal mass, echinoccal cyst and pancreatic pseudocyst. The large calcified mass measured 10cm. in diameter and did not interfere with renal function.

An abdominal aortogram and selective left renal arteriogram were performed and demonstrated a large renal artery aneurysm measuring approximately 9×10cm. in diameter off the medial aspect of the upper portion of the left kidney. The rest of the left kidney appeared normal. The right kidney was normal.

The patient complained of no pain on either side. No mass was palpable on physical exam, although the patient was a large man. No bruit was detectable over the aneurysm. The patient's past medical history was unremarkable except for mild hypertension under excellent control for many years. Blood pressure was 124/80. Pulse was 64 and regular. After the arteriogram, the patient was questioned further about any past trauma to the left flank. He did reveal an incident that occurred when he was a teenager some 50 years ago. He had fallen from a wagon onto his left side and had experienced pain in the left flank for some time following this, but was never seen by a doctor.



Figure 1
Intravenous pyelogram showing 10cm calcified mass upper pole of left kidney.

Robert E. Winders, M.D., is a board certified diagnostic radiologist affiliated with St. John's Hospital in Springfield. Dr. Winders also serves as a clinical associate professor at the Southern Illinois University School of Medicine.

Lisa S. Radwine, M.D., was a resident physician completing a radiology rotation at Memorial Medical Center and St. John's Hospital in Springfield at this writing. Dr. Radwine has also served on the admissions and peer review committees for the SIU School of Medicine.



Figure 2
To our surprise, the selective left renal artery injection showed a huge renal artery aneurysm. Contrast fills only a portion of the lumen.

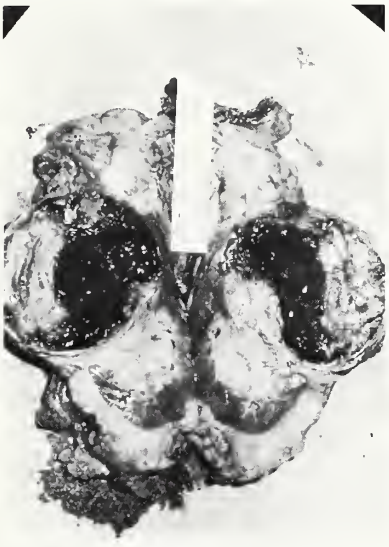


Figure 3
The pathologic specimen showing left kidney and 10cm aneurysm. The aneurysm contained old layered thrombotic material and a lumen with fresh clot.

It was decided that the aneurysm should be removed and surgery was performed. Prior to surgery, the left renal artery was selectively catheterized and an occlusion balloon catheter was inflated, partially occluding blood flow to the left kidney. This procedure is easily done in the radiology department under fluoroscopic control and serves several purposes. First, it decreases blood loss during surgery and gives the surgeon more time to work after the renal vein is ligated. Secondly, it serves as a marker to help the surgeon find the renal artery quickly. The catheter is easily removed by the surgeon at the appropriate time during the surgery.

Pathological Findings

Pathologic examination revealed a left kidney and normal adrenal gland. The upper pole of the kidney was ballooned by a large tumor-like mass measuring 9×10cm. The mass was an aneurysm of the renal artery which had been present for years and had partly destroyed the upper pole of the kidney by pressure. One-half to two-thirds of the kidney remained and appeared completely normal. Three-fourths of the aneurysm contained old layered thrombotic material and the rest contained new clot. Ulcerated arteriosclerotic plaque was present over most of the intima of the aneurysm. Considerable calcification was present. It did not appear that the aneurysm was about to rupture, although on the outer aspect in some areas, the intima appeared completely ulcerated and destroyed. The entire specimen weighed 308gm. The aneurysmal wall weighed approximately 35-40gm. The renal artery abruptly ballooned into the aneurysm with the proximal end of the artery measuring 6mm in external diameter.

The patient tolerated surgery well and was discharged. After his nephrectomy, before his discharge, he underwent a transurethral resection of the prostate gland for persistent urinary retention.

Discussion

A search of the literature found that the largest reported renal artery aneurysm, 8cm in diameter, was treated by a nephrectomy in 1950.[1] Indications for surgery include rupture, risk of rupture, renovascular hypertension, and acute renal failure due to thrombosis of the aneurysm.[2]

A study by John P. Hybert, *et al.*,[3] done at Rochester MN on 67 patients, showed aneurysms ranging in size from 0.3 to 4.0cm with a mean of 1.5cm. Of these, 67% were calcified. Mean age was 61 years. Their follow up ranged 1-17 years with a mean of 5.7 years. All aneurysms remained clinically silent. This study supports the view that patients with asymptomatic solitary saccular renal artery aneurysms may be safely observed without surgical intervention.

Unless hypertension or pregnancy complicates the clinical picture, renal artery aneurysms 1.5cm. or less in diameter can be observed safely by periodic angiography.[1]

Our patient had a calcified renal artery aneurysm measuring 9 × 10cm in diameter which was arteriosclerotic but may have been due to old blunt trauma. The patient's gross hematuria may have been due to his prostatic hypertrophy and unrelated to his aneurysm, but this is unproven. To the author's knowledge these findings have not been reported previously and represent the largest and possibly the oldest renal artery aneurysm reported in the literature. We feel that although the aneurysm had been present for years, surgery was indicated due to its size. Also, this case illustrates the advantages of using a balloon catheter to occlude blood flow prior to nephrectomy.

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Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR, M.D., CONTRIBUTING EDITORS

Surgical Grand Rounds are held weekly on Tuesday at 5:00 pm in the Offield Auditorium of the Passavant Pavilion of the Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of October 5, 1982.

Islet Cell Tumor of Pancreas

Dr. Janet Osuch: A 69 year old white woman was referred from another hospital for diagnosis and treatment of hypoglycemia. She complained of weakness and fatigue of three to four years duration. She had been admitted to another hospital nearly four years earlier and discharged with diagnoses of renal insufficiency, secondary polycythemia, hypertension, and mild emphysema. The patient was treated with chlorthalidone, supplemental potassium and a low cholesterol diet but continued to experience progressive weakness and fatigue.

Patient reported that she had developed episodes of weakness, diaphoresis, emotional lability and inability to converse with her husband two years ago. These episodes occurred in mid-afternoon and lasted between three minutes and one hour. They had increased in severity and frequency and were precipitated by stress.

Three months before this admission, peri-orbital edema and hoarseness had appeared and was treated with levothyroxine sodium with some improvement. A month later, the patient had an office appointment in the afternoon and syncope occurred during the examination. A blood glucose at that time was 20mg%. She was hospitalized and had four more episodes of loss of consciousness with documented low blood glucose levels, relieved by intravenous glucose. These symptoms—loss of consciousness or mental confusion, hypoglycemia, and relief of symptoms with glucose—constitute Whipple's Triad, which was described in 1935 as suggestive of insulinoma.

The patient was transferred to our facility. Physical examination disclosed moderate obesity, emotional lability, and mild peri-orbital edema. The patient related an accurate history and cooperated during the physical examination, although a blood glucose level obtained just prior to the examination was reported to be 26mg%. A constant intravenous administration of dextrose was instituted and frequent blood glucose levels were obtained. Despite the constant intravenous infusion, her blood glucose levels fell as low as 21mg% on several occasions, always in the afternoon. This responded well to oral glucose.

Admission laboratory data were significant: hematocrit 52.8% LDH 44, alkaline phosphatase level slightly elevated with normal calcium, phosphorus, and creatinine levels. Electrocardiogram revealed occasional premature ventricular contractions with a left anterior hemi-block. Pulmonary function tests revealed mild restrictive lung disease. Because of the presence of polycythemia, a liver-spleen scan was obtained and demonstrated hepatosplenomegaly without focal defects. Bone marrow aspiration revealed myeloproliferative changes and myelofibrosis. Phlebotomy was performed, on two

separate days, and two units of blood were removed to be available in the operating room. The purpose of phlebotomy was to decrease her hematocrit below 50 and thus decrease the risk of thrombosis in the perioperative period.

Dr. Sheldon Waldstein: Two questions are posed by this patient. First, were her symptoms associated with hypoglycemia? Second, what was the cause of the hypoglycemia? Normally, insulin is secreted in response to both carbohydrate and protein loads and its secretion is the hormonal mechanism that prevents hyperglycemia. If an exaggerated insulin response occurs, then counter-regulatory hormones are secreted, such as epinephrine, glucagon, cortisol, and growth hormone. The major acute counter-regulatory hormones are epinephrine and glucagon. The response of the patient to an excessive amount of insulin is related to the rapidity of the development of hypoglycemia, which also influences the counter-regulatory response. A rapid fall in blood glucose may result in an epinephrine release, so that the patient has symptoms of tachycardia and sweating. On the other hand, if the blood glucose level falls gradually, epinephrine may be absent and, instead, the patient gets foggy, confused and depressed. We documented chronic hypoglycemia in the present patient, who was remarkably attuned to it and was able to compensate. This has been observed in others with insulomas. You notice that I refer to the lesion as an "insuloma," which is really a more correct name. An insuloma is a tumor of the islets; an insulinoma is tumor of insulin, and insulin does not form tumors. The islet cells have the tumor. Efforts to have the medical community adopt the term "insuloma" have failed. Therefore, I will say insulinoma from this point on. Similarly, the term "glucagonoma" is not really correct.

Etiology Considered

Hypoglycemia was documented in this patient and the symptoms were associated with the hypoglycemic state. Our next question was, why did she have the low blood sugar level? The most common cause of low blood sugar encountered in medicine is a diabetic who takes too much insulin. It is of interest that patients with diabetes on insulin have been known to develop insulinomas. Fortunately that is relatively rare and presents an extremely difficult diagnostic problem. If the patient is not a known diabetic taking insulin, consideration must be given to the factitious use of insulin. There have been many cases in which patients have injected insulin, causing hypoglycemia. Another consideration is tumor hyperglycemia, where various large mesenchymal tumors of the abdomen and chest develop factors which produce hyperglycemia. This was unlikely in this patient. Such tumors are usually large and would have been evident in chest X-ray, abdominal CT scans, or ultrasonography.

Another possibility was that she could be taking an oral hypoglycemic agent such as chlorpropamide. This was considered because, despite her day-long hypoglycemia, the patient's symptoms were generally in the afternoon. You might expect such a response from an intermediate dose of insulin injected in the morning.

Next we try to identify a tumor, if present. If she does have an insulinoma, it may be an isolated phenomenon or it may be part of a multiple endocrine adenomatosis syndrome (MEA). MEA I is associated with parathyroid adenomas and with pituitary adenomas. In addition, islet cell adenomas may secrete more than one hormone so that factors other than insulin hypersecretion may be present. The serum calcium level was normal, which diminishes the likelihood of MEA syndrome, although the presentation of adenomatosis of one organ system may preceed presentation in other organ systems by years. Our patient was not significantly hypometabolic but the TSH level was slightly elevated. This would imply a somewhat less than complete thyroid replacement. Cortisol levels and measurable amounts of ACTH were normal. The pituitary adrenal function was satisfactory.

The next step was to seek evidence of hyperinsulinism and to document an inappropriate insulin response. If a normal person were to receive a large amount of glucose, hyperglycemia would develop. Elevated insulin levels in the blood of that person would be an appropriate physiologic response to the hyperglycemia. However, if a patient is normoglycemic or hypoglycemic, and has elevated serum insulin levels, an inappropriate response is present and suggests autonomous secretion from an insulinoma. The key is, first to document hypoglycemia. This is accomplished best by fasting. The majority of patients with insulinomas become symptomatic in 48 hours or less. Occasionally, a fast of 72 hours is required. During the fast, serum insulin levels, as well as blood glucose values, are obtained. The normal patient will cease producing insulin as hypoglycemia develops. The insulin to glucose ratio is helpful. When the insulin to glucose ratio, (insulin in microunits to glucose in milligrams) is greater than 0.3, autonomous insulin secretion is present. In this patient, initial study demonstrated a blood sugar of 68 and an insulin level of 54: thus an insulin to glucose ratio of 0.8. When she was markedly hypoglycemic, with a blood glucose level of 26mg per cent, she had an insulin value of 37 microunits, or an insulin to glucose ratio of 1:4.



Figure 1
Selective arteriogram of celiac artery demonstrated splenic artery aneurysm but evidence of a tumor blush was absent.

Because a ratio of 0.3 is suspicious, this would appear to be diagnostic.

How do we know that the patient is not injecting herself with insulin? One can assay circulating insulin antibodies. When animal insulin, porcine or beef, or mixtures of the two, is injected, insulin antibodies will develop after a period of time. We did not look for insulin antibodies in this patient. We were reasonably sure that she did not have insulin antibodies circulating because insulin antibodies interfere with the radioimmuno-assay of insulin. (IRI) When insulin antibodies are present, IRI values are in the range of 200-400 or higher.

Instead, we obtained specific physiologic tests that differentiate exogenous from endogenous insulin. Insulin is synthesized from a much larger molecule called proinsulin. The pancreas synthesizes the long chain of proinsulin, which is joined together by disulphite bridges. When the proinsulin is secreted, the disulphite bridges are split, producing insulin and C-peptide. When the pancreas is secreting insulin, it is secreting a proportionate amount of C-peptide. If exogenous insulin is injected into a person and produces hypoglycemia, the body's physiologic response is to turn off the pancreatic insulin secretion. Under this circumstance, assay will detect a lot of insulin but no C-peptide, because the commercial insulin does not contain C-peptide. Therefore in a patient with hypoglycemia and hyperinsulinism, an increase in the amount of C-peptide originates endogenously. If there is hypoglycemia and hyperinsulinism but no C-peptide, it originates exogenously. In the patient presented today, the diagnosis seemed secure. She was found to have hypoglycemia, hyperinsulinism, and an elevated C-peptide.

Dr. Janet Osuch: Before exploration, a preoperative attempt at tumor localization was made by CT scan and selective arteriography.

Dr. Scott Bernstein: The CT scan, as well as the angiographic study, did not localize the tumor in this patient. Large islet cell tumors can be identified by computerized tomography of the pancreas, if they are centripetal and change the shape of the pancreas. Hepatic metastases may be detected when present. Angiography revealed several interesting findings. Selective study of the celiac axis revealed aberrant origin of the right hepatic artery, which arose from the main celiac axis, rather than the proper hepatic artery. This is a normal variant. Visualization of the splenic artery demonstrated a splenic artery aneurysm (Figure 1). No tumor blush was noted in the area of the pancreas. A selective superior mesenteric artery injection was performed and, again, failed to demonstrate a tumor blush.

Dr. Janet Osuch: Surgery was performed two weeks after admission. The gastrocolic ligament was divided and the entire pancreas was mobilized. The pancreas was normal to palpation and a mass could not be felt. Distal pancreatectomy was performed which included aneurysm. As the distal portion of the pancreas was mobilized, a 2cm×1.5cm firm, tan tumor was found at the splenic hilum. Drains were placed at the transected end of the pancreas and brought out laterally. The abdomen was closed.

Dr. Stephanie Young: The specimen consisted of a portion of the body of pancreas with the tumor nodule located in the distal end of the pancreas. The tumor measured 2cm×1.5cm×.5cm. The splenic artery was found on the superior margin of the specimen and an aneurysm was present near its proximal end. The tumor was very well circumscribed. It was attached to the tail of the pancreas by a rather narrow pedicle of normal pancreatic tissue. The tumor itself was composed of a solid mass of yellow tissue, which was quite hemorrhagic. Microscopically, tumor consisted of a very monotonous population of tumor cells which lay in nests, and are divided by stroma of varying thickenss (Figure 2). It should be emphasized that the differential diagnosis of malignant or benign islet cell tumors is quite difficult cytologically. These tumors, benign or malignant, have a similar histologic appearance. Malignancy is suggested by inva-

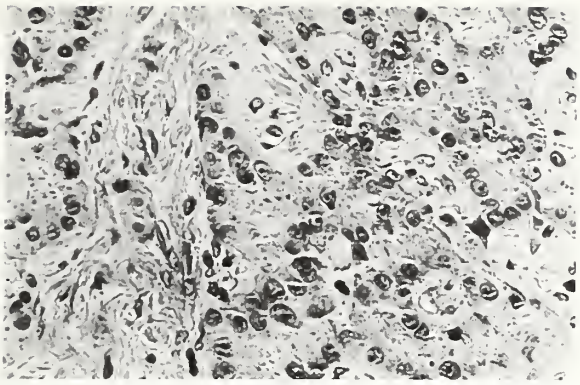


Figure 2
High power view of the insulinoma showed apparently uniform tumor cells separated by fibrous stroma.

sion of the stroma or blood vessels. The actual diagnosis of malignancy is based on the clinical behavior of the tumor, specifically metastasis to the lymph nodes or the liver. The tumor in the present patient appears to be benign.

Dr. Janet Osuch: In regard to the classification of insulinomas, approximately 80% are solitary, 10% present as part of the multiple endocrine adenoma syndrome, and 10% are malignant. Rarely can islet cell hyperplasia be the cause of hyperinsulinemia and this is found most commonly in children. Preoperative localization of the tumor remains a challenge. Selective arteriography and computerized tomography have been used. The latter has demonstrated tumors greater than 2cm in diameter. However, success rates in published reports have varied in localization of smaller tumors concerning the CT scan efficacy. The majority of insulin tumors are small, 0.5 to 2cm in diameter. The first demonstration of an insulinoma preoperatively was described in 1963 by Olson using arteriography. The reported success rate of preoperative tumor localization by this method has varied between 38-85%. The success rate depends on the degree of tumor vascularity and on tumor size. Super selective arteriography with injection of the superior pancreatic duodenal artery and the addition of magnification, sterioscopy and subtraction techniques have added to the sensitivity. However, the frequent false positive and false negative results have been discouraging.

New Technique

In 1975, a new technique for preoperative tumor localization, transhepatic portal vein catheterization, was proposed. In this technique, a catheter is placed, under fluoroscopic guidance, into the portal vein and then into the superior mesenteric and splenic vein. Blood samples are obtained along the length of the pancreas and analyzed for insulin by radioimmunoassay. The insulinoma is then localized to the area producing the highest insulin level.

Lancet published a 1981 study by Daggert of 33 patients, in whom he had attempted preoperative tumor localization using ultrasound, CT scan, selective and superselective arteriography, and transhepatic vein sampling for localization. He found that only the last technique was useful. He stated that an experienced surgeon has very high probability of being able to palpate a tumor at surgery, and that preoperative localization is not usually needed. In fact, all tumors demonstrated by ultrasound, CT scan, or arteriography were palpated at surgery. It is still essential that the entire pancreas be mobilized and explored, for the purpose of detecting multiple adenomas and insuring a cure.

A frequent method that has been used to determine that the tumor has been excised is intraoperative measurement of blood glucose levels at 15 minute intervals. This is based on the assumption that after removal of an insulinoma, a prompt rise in blood glucose will indicate that the tumor was a solitary lesion and that the patient is cured. Several reviews have reported that expected rise in blood glucose levels following tumor excision does not always occur. In a study of 35 patients from the Mayo Clinic, two types of responses of blood glucose to tumor excision were seen. A total of 27 patients demonstrated the predicted hyperglycemic rebound within 30 minutes of tumor excision. However, eight patients failed to have an increase in blood glucose up to 90 minutes following tumor excision, although all eventually did have a return to normal blood glucose levels. Therefore the use of blood glucose levels as an indicator of tumor excision is not entirely reliable. In our own patient, blood glucose levels were determined every 15 minutes during the operation. In addition, insulin levels were obtained at the same time, although the results of these levels were not available for several days after the operation. There was a predictable rise in the blood glucose level following the induction of anesthesia, although glucose was not administered during surgery. The glucose level became stable between 190 and 220mg% until the insulinoma was removed. After the tumor was excised, there was a prompt increase in the blood glucose and 90 minutes later the glucose had risen to 255mg%. Interestingly, the insulin levels were undetectable after the excision of the tumor. The patient did require regular insulin in the immediate

postoperative period, but by the time of discharge the blood glucose level was 106mg% without insulin.

The overall results of the surgical treatment of insulinoma are good, with more than 90% relief of hypoglycemia. Long-term follow-up is important in these patients. One study found that a significant number of patients manifested significant neuropsychiatric disease between 1 and 24 years after operation, as evidenced by tension headaches, erratic behavior, and institutionalization for psychosis and depression. Some of these patients also develop adult onset diabetes. In addition, more than 36% of these patients had documented peptic ulceration in their 24 year postoperative follow-up period. 80% had a severe upper gastrointestinal hemorrhage and 50% of them died from the hemorrhage.

Summary

Insulinomas are intriguing tumors that challenge the surgeon's diagnostic abilities and intra-operative decision-making skills. These patients require long term follow-up for development of neuropsychiatric disorder, diabetes mellitus, peptic ulcer disease, recurrence and unsuspected evidence of metastasis.

Dr. John M. Beal: Insulinomas are uncommon tumors. Present diagnostic methods are now quite good in determining the presence of an insulinoma. However, pre-operative localization remains uncertain. The present patient is an excellent example of both points. We were fortunate, in a sense, that she had a splenic artery aneurysm because that required treatment. As part of the treatment of the aneurysm as well as the search for the insulinoma, we did a distal pancreatectomy. Immediately, the tumor was detected in the hilum of the spleen. Incidentally, the splenic artery was removed with the distal pancreatectomy, but the spleen was not removed. This can often be accomplished and avoids exposure of the patient to post-splenectomy sepsis. ◂

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Obituaries

***Boyles, C. F.,** DeKalb, died September 21, 1983 at the age of 50. Dr. Boyles was a 1957 graduate of the University of Illinois College of Medicine, Chicago.

****Downing, M. Elizabeth,** Des Moines, Washington, died April 24, 1983 at the age of 77. Dr. Downing was a 1932 graduate of Rush Medical College, Chicago.

***Frack, Herman,** Oak Park, died September 26, 1983, at the age of 68. Dr. Frack was a 1945 graduate of the University of Health Sciences/ Chicago Medical School.

****Freeland, John Elder,** Waukegan, died April 24, 1983 at the age of 83. Dr. Freeland was a 1928 graduate of Rush Medical College, Chicago.

***Hanselman, Russell C.,** Auburn, Indiana, died August 9, 1983 at the age of 74. Dr. Hanselman was a 1935 graduate of Johns Hopkins University School of Medicine, Baltimore.

***Harris, James Frank,** Lighthouse Point, Florida, died September 24, 1983 at the age of 75. Dr. Harris was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

****Herzog, Max,** Rock Island, died November 24, 1983 at the age of 81. Dr. Herzog was a 1925 graduate of Friedrich-Wilheims-Universitat Medizinische Fakultat, Berlin, Germany.

***Laimins, Peter T.,** Bensenville, died July 16, 1983 at the age of 60. Dr. Laimins was a 1950 graduate of Medizinische Fakultat der Eberhard-Karis-Universitat, Tubingen, Baden-Wurttamburg, Germany.

***Lutz, J. Frederick,** Sturgis, South Dakota, died November 7, 1983 at the age of 73. Dr. Lutz was a 1938 graduate of Rush Medical College, Chicago.

***Nykiel, Florian R.,** Deerfield, died November 11, 1983 at the age of 53. Dr. Nykiel was a 1960 graduate of the University of Illinois College of Medicine, Chicago.

***Rosenblum, Samuel S.,** Centralia, died November 7, 1983 at the age of 72. Dr. Rosenblum was a 1936 graduate of the University of Health Sciences/ Chicago Medical School.

Sprechner, Herman C., Evanston, died September 24, 1983 at the age of 60.

***Zaldivar, Raul A.,** Oak Park, died November 5, 1983 at the age of 60. Dr. Zaldivar was a 1948 graduate of Facultad de Ciencias Medicas de la Universidad de Buenos Aires, Argentina.

**Indicates ISMS member.*
***Indicates member of Fifty Year Club.*

Special Articles

Leadership Conference Summary

The Physician's Role in the '80s

During the weekend of November 12-13, more than 300 ISMS members and guests met in Decatur to study and debate the physician's place in contemporary medicine. Nationally prominent speakers catalyzed dynamic interchange in more than a dozen workshops and seminars.

Introductory remarks by ISMS President Robert P. Johnson, M.D., focused on flexibility. Each physician must balance roles as clinician, economist, negotiator, legal expert, reviewer, communicator and political organizer, Dr. Johnson said. Ignoring any one responsibility would hurt each of the rest. The '80s could provide a fine opportunity for American medicine to gain new dimensions, he added. It was medicine's challenge to define the parameters of that opportunity.

Other speakers warned that economic forces would be key factors through the remainder of the decade. They agreed that a passive response was no longer enough. Physicians were urged to be vigilant and cooperative. They were encouraged to become active in grass roots politics.

Economic Overview

Jeff Goldsmith, Ph.D., president of Health Futures Inc., and author of "Can Hospitals Survive: The New Competitive Health Care Market," opened the program with an analysis of contemporary health care economics.

"As many of us have begun to realize, the economic pressures which have begun to bear on American medicine have started to interfere with the traditional protections of the physician/patient fee-for-service relationship," Goldsmith told the group. In addition to cutbacks in federal reimbursement programs, he said, "our nation's private insurers and employers have become increasingly surly" about reimbursement.

"Adjusting to this era of rising expectations and diminished resources forms the greatest challenge physicians face today," he stressed.

Pointing to the "never easy relationship between hospitals and medical staffs," Goldsmith said that "if either the hospitals or their medical staffs proceed solely for self-interest, both parties will lose."

"If the hospital doesn't take steps to support and reaffirm the private practice of medicine in the community, they're going to have an awfully hard time holding their own in an increasingly competitive environment," Goldsmith predicted.

At the same time, he said, physicians must recognize that hospitals are "the most economically fragile, least mobile and most visible target of economic pressures."

ISMS Professional Liability Initiative

Physicians attending the session on the ISMS professional liability initiative heard Fred Z. White, M.D., chairman, Illinois State Medical Inter-Insurance Exchange (ISMIE) Board of Governors, discuss the need to educate physicians, lawmakers and the public about the new malpractice liability crisis. Tracing the history of the Exchange, Dr. White related how commercial professional liability insurance companies had been priced out of a volatile market in the first malpractice crisis. While ISMS' action in forming the

Exchange had stemmed a potential crisis of availability, the overall malpractice problem had, to date, defied all attempts at resolution.

From its inception, the Exchange's accumulated average indemnity payment has grown to $96,552, Dr. White told the group. However, the 1982-83 policy year had shown a very disturbing trend: the average payout had been $132,476.

The claims situation has forced ISMIE loss reserves up to $346 million as of June, 1983, Dr. White said. The average premium paid had risen to $9,469 for the 1983-84 policy year, a 127% increase from the first policy year (1976-77) average premium payment of $4,168.

Between 1977 and 1983, health care-related suits increased drastically, Dr. White said. Most of these claims continue to be non-meritorious, he added. Since the company's inception, about 81% of all claims have been closed without indemnity payment.

After reviewing these data, Dr. White explained that the ISMS Board of Trustees and ISMIE Board of Governors had agreed to test ISMS membership support for a legislative reform effort. ISMS had conducted a mail survey of every member plus a random sample telephone survey to determine the strength of member support for a major effort to curtail the growing malpractice crisis.

ISMS legal counsel John Simon presented the criteria for a legislative reform package that may be sought by ISMS.

It might be possible to cap non-economic losses without limiting direct damages in malpractice cases, Simon said. This would permit placing some limit on the less tangible losses for "pain and suffering" and other damages not specifically linked to economic loss. Earlier Society-backed legislation to cap all awards was overturned by the Illinois Supreme Court.

Simon described a second proposal, which would permit periodic rather than lump sum payments for awards exceeding $50,000. Under this provision, payments would not be transferable, and would cease upon the plaintiff's death.

Legislation to provide three separate screening panels—of judges, attorneys and county medical society representatives—was discussed by Simon. Under such a proposal, the plaintiff could elect to proceed in filing suit despite a panel recommendation to the contrary. However, the panel finding would be admissible in court, and if the ultimate award were less than court costs, the plaintiff would be liable for those costs.

Another proposal under consideration would permit health care personnel listed as defendants in malpractice suits to file affidavits attesting that they had no involvement in the incident. The judge would be asked to evaluate the affidavits and, if appropriate, remove the defendants from the case.

Simon characterized the proposed legislative initiative as a package of measures to permit the physician to guarantee his patients access to quality medical care. Dr. White joined him in calling for a response similar to that earlier this year, when physicians were asked to write and call their representatives prior to a vote on pre-judgment interest. That bill would have assessed interest on malpractice awards from time of occurrence rather than time of judgment. It was soundly defeated by legislators, who received more than 1,000 pieces of correspondence from Illinois physicians.

Simon and Dr. White cautioned that a grassroots legislative effort would be an uphill battle which could easily fail without the wholehearted participation of the physician membership.

Health Care Economics

Frank Watson, M.D., president-elect, Medical Society of New Jersey, related experience in his state with prospective payment systems.

While the DRG system in Illinois is limited to Medicare patients, he said, the New Jersey pilot plan imposed prospective payment mechanisms across the board. That prevents New Jersey hospitals from shifting costs to other third party payors, Dr. Watson said, as hospitals in other states are certain to do under the DRG system. Dr. Watson predicted that DRGs would very soon apply to all payment systems.

Under the DRG system, Dr. Watson explained, an imprecise diagnosis might not have negative medical consequences, but it could have extensive financial repercussions. A hospital administrator can control 40% of costs as out-of-pocket expenses for maintenance and equipment, he said. The balance is determined by day-to-day actions of the medical staff. As a result, a failure to cooperate could be disasterous to the hospital.

"Physicians in New Jersey are being asked to paticipate in hospital activities in ways they never have before," Dr. Watson said. "They are being asked to make DRGs work. We now have the challenge of providing that care which is needed: no more, no less."

Comprehensive analyses of physician practice patterns have also become routine as a result of the DRG implementation, Dr. Watson said. Each physician can plainly see how his behavior over the year has affected the hospital's economic status, he added.

PPOs Examined

Marian C. Jennings, group vice president, Amherst Associates, discussed the structure of

Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs).

At its heart, Jennings said, each is an insurance mechanism. Under a PPO system, she said, a limited group of health care providers agree to specified, discounted fees for a specific group of persons. The patients are not required to limit themselves to these physicians, but doing so will eliminate or drastically reduce out-of-pocket costs. The benefit levels are flexible. Utilization review and management information systems are typical. The administrative cost, Jennings told the group, is low. The claim turnaround time provides a cash advantage for physicians.

An EPO, she said, is a similarly structured closed panel system, but patients are required to stay with specified providers in order to maintain coverage.

Jennings added that while the proposed Preferred Provider Health Care Act of 1983 (if passed) would override any state law restricting PPO negotiations, potential antitrust issues had not been adequately addressed. She warned that physicians interested in PPOs should be aware of possible antitrust aspects which should be discussed with individual attorneys. (ISMS legal counsel is developing guidelines to assist physicians in this area.)

Jennings suggested that a successful PPO effort would depend upon a careful definition of patient pool and marketing strategy. Competitive rates and shared risk among participants were equally important, she said. Quality assurance and utilization review programs were crucial, as were information systems allowing price and volume variance identification.

Jeff Goldsmith returned to the podium to explore the structure of new health care systems. To date, he said, the most enduring alternative financing mechanism had been the Health Maintenance Organizations (HMO). The key to all alternative financing systems, he opined, is risk assignment.

Goldsmith said that the federal department of Health and Human Services (HHS) had begun to encourage elderly patients to join HMOs. In 1981, several of the larger HMOs had succeeded in reducing average Medicare hospital days from 4100 to 1700 patient days per year. "If there is an HMO in your community," Goldsmith told physician attendees, "your elderly patients will have a great incentive to join it."

Mandatory Reporting/Due Process Procedures

Saul Morse, J.D., ISMS legislative counsel, and Marshall Segal, M.D., J.D., former chairman, ISMS Medical-Legal Council and a member of the ISMS Ad Hoc Committee on Due Process, chaired this forum. The program centered on procedures and rules implementing the new Illinois mandatory reporting law and due process considerations in medical staff appointment, reappointment and discipline.

Dr. Segal and Morse told the audience that the mandatory reporting amendments to the Illinois Medical Practice Act (which had become law as of January 1, 1983) have not been well tested. The amendments require reports of formal disciplinary action taken as the result of events directly related to patient care which are believed to constitute unprofessional conduct. Parties taking reportable action could be health care institutions, professional associations, liability insurers, public agencies and states' attorneys. The law provides immunity for all good faith reports, the speakers said.

Morse and Dr. Segal emphasized that impairment is treated as a separate category under the law. If a physician agrees to enter a rehabilitation program and present ongoing reports for as long as necessary, the state will simply monitor progress through these reports and not initiate disciplinary proceedings.

Reported impaired physicians will receive a complete copy of the report from the Department. Those reported for licensure/disciplinary action are advised that a report has been filed, but must specifically request a copy via notarized letter in order to read the particulars. Morse stressed the importance of reviewing the reports. Persons who review their reports and submit a written response within 30 days of notice that the report has been filed, he said, can eliminate later difficulties by providing additional evidence for the initial review.

(*Editor's Note:* A thorough review of the mandatory reporting law is scheduled for an upcoming issue of *IMJ.*)

A Federal Perspective

Illinois Congressman Edward Madigan (R-15) gave an informal address at the Saturday evening dinner which followed the day's seminars.

Rep. Madigan related events that week in Washington which saw the House Ways and Means Committee *defeat* proposed measures to roll back and freeze Medicare payments to physicians for hospital inpatient services and require that physicians accept assignment of all Medicare claims for inpatient services. During the budgeting process, unsuccessful efforts also were made to introduce these measures as amendments on the floor.

Predicting an overhaul of the Medicare program by 1987, Rep. Madigan said "DRGs are doomed to fail."

Saying that Reagan administration spending on social programs actually compared favorably to that of previous administrations, Rep. Madigan

called for support of the goals represented by the Reagan administration's programs and policies.

UCR vs Indemnification

The Sunday morning breakfast session dealt with a proposed report by the American Medical Association's Council on Medical Service regarding payment for physician services. The report, which was to be presented at the AMA's Interim Meeting, encouraged that the concept of indemnity be considered in preference to Usual, Customary or Reasonable (UCR).

While ISMS representatives currently are bound to support UCR by House of Delegates policy, issuance of the AMA council report had prompted debate over possible attempts to revise ISMS policy at the next House of Delegates meeting.

Robert P. Johnson, M.D., ISMS president, said that "UCR used to mean usual, customary *or* reasonable, with 'reasonable' designed to cover additional costs. However, third parties have changed UCR to mean usual, customary *and* reasonable, with the 'reasonable' component intended to serve as a limiting factor."

Arthur R. Traugott, M.D., ISMS trustee and member of the society's delegation to the AMA, suggested that UCR "is not working," and that the Federal Trade Commission has "taken away the reasonable element" of UCR. In addition, "Medicare has totally corrupted UCR to fit into its own system," Dr. Traugott said.

Joseph R. O'Donnell, M.D., another member of the Illinois AMA delegation, said that third party payors have been "misinterpreting" the reasonable portion of UCR to serve their own interests. However, he spoke against indemnity, calling it the groundwork for a physician reimbursement fee schedule.

Legislation and IMPAC

ISMS President-Elect Robert C. Hamilton, M.D., moderated a panel on legislation and IMPAC. He detailed the nature of ISMS' political activity, and the history of IMPAC as a political arm to support candidates who support medicine. Dr. Hamilton stressed individual participation in IMPAC and the ISMS Key Contact Program.

Alfred Balitzer, Ph.D., author of "A Nation of Associations," related professional alliances, such as medical societies, to the fabric of the American way of life. "We Americans compete peacefully to make our voices heard and persuade others to our point of view," he said.

"Associations are the fundamental unit of our political, social and fraternal existence," he said. "This distinguishes America from all other countries. Associations enable Americans to do for themselves what, in other countries, government does for you."

Decrying those who denigrate political action committees and special interest groups, Balitzer called for an assertive stance. "If we do not take the moral high ground, if we do not defend our associations, our PACs, in terms of fundamental democracy," he said, "if we stay on the defensive, then those who oppose us are sure to win out."

U.S. Representative Richard J. Durbin (D-20th) focused on individual communication. He said the growth of PACs indicates that many Americans prefer to support a PAC rather than individual candidates.

In support of intelligent lobbying, Durbin said that he is usually contacted by representatives of medicine, insurance, labor and real estate on any health related legislation. Not all special interest groups have a strong financial base, he said, but all effective ones are good communicators.

Durbin said that form letters or mass-produced postcards are not effective mechanisms. He urged that individuals write their representatives about important bills. "Be specific, be timely and be concise," he said.

Illinois State Representative Judy Baar Topinka (R-43) compared the legislative process to football: "If you have the numbers, you win," she said. "If you don't have the numbers, you lose."

Topinka predicted that optometric drugs, Baby Doe and pre-judgment interest in medical malpractice cases would be recurring themes before the legislature. Noting that each was a very close vote that could change radically if a few new legislators were elected, she urged that physicians participate in upcoming elections, and consider running for political office.

"If you can invest in the stock market and if you can invest in your community, then I think you had better invest in your profession," she said, "because government is your full time partner from here on out."

Professional Review Organization

ISMS Board of Trustees Chairman Warren D. Tuttle, M.D., opened the panel on professional review organizations (PRO) by explaining recent action by the ISMS Board of Trustees. After long study, the Board had determined that ISMS (1) would not seek designation as a statewide PRO; (2) would seek dual PRO designation for Illinois and provide resource capacity to physician groups seeking that designation and (3) would provide resource capacity to existing physician review groups applying for designation if Illinois were designated as a single PRO area.

Dr. Tuttle told the group that the Board had

taken these positions for many reasons. One, he said, was that "we didn't want to re-invent the wheel." Another was that "we did not feel it would be right for ISMS to expend your dues dollars to regulate your practice."

Dr. Tuttle commented on the close relationship between PRO and Diagnosis Related Groups (DRGs). "The incentives have changed from counting days to appropriateness of treatment," he said.

Maynard I. Shapiro, M.D., president, Chicago Foundation for Medical Care, provided a brief history of prospective payment systems.

Dr. Shapiro said he anticipated that a PRO system would effectively change hospital utilization review. "Hospital utilization review will now be mainly an educational function," he said, and urged that physicians seek out information and education to prepare for the new system.

Harold J. Kolb, M.D., president, East Central Illinois Foundation for Medical Care, pointed out that the DRG system would encourage physicians to limit diagnoses to one per patient and treatments to one per admission.

Dr. Kolb described a number of aspects which separate PRO from its predecessor in utilization review, PSRO. "PSRO gave a presumptive waiver of liability," he said. "Under PRO, liability will be dealt with on a case by case basis."

PRO review will assess admission objectives for a random sample of 5% of admissions, he said. If 25% of those were questionable, all admissions would be reviewed. Review is also mandated for all transfers and readmissions, he said, as well as for a number of DRG designations.

Hospital Medical Staff Organization

Dennis O'Leary, M.D., president, District of Columbia Medical Society and medical director, University Hospital, George Washington University School of Medicine and Health Sciences, and John J. Ring, M.D., AMA and ISMS trustee and chairman of the AMA Study Committee on Hospital Medical Staffs, told physicians to expect continuing economic pressures with respect to their hospital practices.

"The capacity of our health care system outstrips the resources available to support it," Dr. O'Leary said. He added that bio-ethical considerations had not kept pace with technology and he cited a "public policy paralysis," on such tough questions. He predicted that the face of medicine would continue to change: "By 1990, 40% of American physicians will have entered practice after 1980," he said.

"Cost considerations are going to play a tremendous role in our activities as physicians," Dr. Ring told the group. "We have to sit down with our hospital governing boards and discuss divergent interests. We are in a position now where we could destroy our hospitals."

Calling for cooperation with hospital administrative personnel, Dr. Ring urged that medical staff members "sit down and do some strategic planning, program planning and operational planning. The budget is the most important tool at this level of planning," he said.

"We are primarily advocates for our patients, not ourselves," Dr. Ring concluded. "It's not whether the physician has a vote on the hospital governing board; it's whether he has the means to get representation for the feeling of the medical staff on the hospital board."

S.B. 495

ISMS First Vice President Ronald Welch, M.D., served as moderator for the session on Illinois Senate Bill 495, the proposed Hospital Revenue Act. Dr. Welch noted that the issue had received considerable attention in the last legislative session. (The bill had been strongly *opposed* by ISMS and the Illinois Hospital Association.)

A relatively rare parliamentary maneuver had suspended action on the bill in its final passage stage. Dr. Welch explained that a Senate Select Committee and technical advisory panel had been created to study the bill. The technical advisory panel, Dr. Welch said, includes 22 members representing hospitals, physicians, business, labor, insurance companies and senior citizens. Drs. Alfred J. Clementi and Fred Z. White are ISMS representatives. The Senate Select Committee was to evaluate the panel's findings and write a final report for presentation to the full Senate by March 1, 1984.

The bill's sponsor, Senator Prescott Bloom, stressed that it was only a prototype for a prospective payment system. "Senate Bill 495 is only a starting point. The whole idea is to get off cost-based reimbursement," he said. "We can look at any mechanism to do that. The current system rewards the inefficient and penalizes the efficient hospital. We have to get on a prospective payment system."

Alfred J. Clementi, M.D., discussed factors that have raised the cost of medical care. Health care represented 4.5% of the GNP in 1950 and 10.5% of the GNP in 1982," he said, citing improved technology, malpractice, defensive medicine and higher labor costs as contributing factors. He predicted that the situation would become even more critical as the average age of the U.S. population continued to increase. While 11% of the population is over 65, he told the group, that segment of our population receives ⅓ of all health care services.

Dr. Clementi warned that no single, simple remedy would resolve the health care cost crisis.

Andrew Melczer, PhD., ISMS consultant on hospital finance and former senior economist at the Northwestern University Center for Health Services and Policy Research, described technical problems with the bill's content. Melczer explained that the language had been modeled on a 1982 Massachusetts law. However, he said, Massachusetts already was on a prospective payment system when the hospital revenue cap issue came up there. Also, numerous other issues had already been negotiated between hospitals and third party payors. For those reasons, he concluded, the mechanisms are not easily transferred to Illinois.

Loss Prevention

ISMS Loss Prevention Committee Chairman Alfred J. Clementi, M.D., traced the history of the ISMS Loss Prevention program. The malpractice climate has worsened since the program's inception in 1979, Dr. Clementi said. The original two hour case study format has grown to one-and-a-half day workshops, he added, which now include such related issues as communication skills.

Sara Charles, M.D., associate professor, clinical psychiatry, University of Illinois Abraham Lincoln School of Medicine, presented data on the impact of malpractice suits on the personal and professional lives of physicians.

A recent Florida survey, she said, showed that, mostly because of liability risk, 25% of fully qualified OBGYNs had withdrawn from that specialty and another 30% planned to withdraw soon. Noting that such fears were increasingly commonplace, Dr. Charles expressed concern that reluctance to enter and stay in high risk specialties represents a loss of available medical care.

Dr. Charles reported results of her study of physicians as subjects of malpractice lawsuits. Physicians typically deal with high levels of stress in daily practice, she said. When sued, they also tend to internalize the stress of the malpractice litigation.

"Characteristically, they use a defense mechanism called suppression," Dr. Charles said. "If asked, they can talk about it, but ordinarily they push it out of their conscious lives."

"A malpractice suit touches the core of your personal and professional identification," Dr. Charles told the group. "It affects the heart of medicine because of its impact on clinical judgment and the doctor/patient relationship."

"The charge of medical negligence and malpractice litigation," she said, "constitute a major external source of inhibition of the free exercise of clinical judgment which is the essence of being a physician."

Dr. Charles reported that 21% more suits were filed in Cook and the six collar counties during the first nine months of 1983 than over the same period in 1982.

"The basic issue," she said, "is social and cultural. It derives from an historical tension between the law and insurance over the sources of compensation for injury. Only when patients realize they are the ultimate victims of a crisis which is affecting physicians and the quality and availability of their health care, will changes occur."

Dr. Clementi reviewed generic screening criteria for hospital procedures and discussed the morbidity/mortality/malpractice conference format for internal hospital review. "The important consideration is that these things are translating to effects on our patients," he said.

Donal D. O'Sullivan, M.D., Ph.D., J.D., medical director, Illinois State Medical Inter-Insurance Exchange and vice president, Chicago Academy of Law and Medicine, discussed loss prevention and risk management programs for the hospital setting.

"Somewhere between 70 and 80% of all malpractice incidents occur in the hospital setting," he said. He urged that physicians work with hospital personnel to share information efficiently. If there are problems of this nature, he said, they should be identified as hospital business. "It is never wise for the physician to accept responsibility for anything over which he has no authority," he said.

"Be sure your hospital risk management program is a good one," he told the group. "Make sure that it identifies problems, that it provides corrective action, and that it has at least as much teeth as utilization review. Recognize risk management as a specialty in its own right."

Evaluation

Evaluation forms completed by physicians attending the leadership conference were overwhelmingly favorable. The vast majority found the calibre of the speakers to be a major benefit. Many said that sections on legislation, the professional liability initiative and health economics were particularly helpful and called for an update session in 1984.

"I'm always pleased to to see my basic belief in the physicians of Illinois reaffirmed," ISMS President Robert P. Johnson, M.D., said in conclusion. "The attendance and response show that our colleagues are determined to stay on top of the many changes affecting their profession and their patients." ◀

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

BEARDSTOWN: Population of 7,000 with a service area of 30,000. Located 45 miles from Springfield. Under contract management of Memorial Medical Center. New three person medical office building. First year guaranteed income plus other benefits. Recreational facilities nearby. CONTACT: Jeffrey L. Martin, P. O. Box 350, Beardstown 62618. (217) 323-2720. (4)

BREESE: Serving population 25,000. Need family practice physician for Carlyle (8 miles from hospital). Financial assistance available. 40 miles east of St. Louis, near Carlyle Lake. Excellent recreational opportunities. Quality schools and colleges in area. Contact: Sr. Mary Anthony, St. Joseph's Hospital, Breese, 62230. (618) 526-4511. (3)

BREESE: Serving population 25,000. 40 miles east of St. Louis, near Carlyle Lake. Need OB-Gyn physicians to share practice with present OB-Gyn physician. Need family practice. Quality schools and colleges in area. Financial assistance available. CONTACT: Sr. Mary Anthony, St. Joseph's Hospital, Breese, 62230, (618) 526-4511. (3)

DU QUOIN. Orthopedic surgeon needed for clinic and surgical services. Fully equipped office adjacent to X-ray and emergency. Complete support services inhouse. Excellent opportunity in rural medicine. 20 miles from SIU-Carbondale. Beautiful community 70 miles southeast of St. Louis. David R. Hosler, Administrator, Marshall Browning Hospital, Du Quoin 62832, 618-542-2146. (4)

LA HARPE: Population 1200. Seeking replacement for one or two family physicians in community. 64 bed hospital including 49 long term; affiliation with nearby regional medical center; office facilities and financial assistance available. Educational/recreational facilities. Mississippi River nearby. Contact: Richard Miller, Administrator, La Harpe Hospital, La Harpe 61450, 217/659-3011. (1)

LEMONT: OB-GYN—Board certified or board eligible. Growing community—thirty minutes southwest of Chicago. Congenial physician group. Many fringe benefits—salary negotiable. Excellent practice opportunities. Contact Barry Ladd, M.D., 217 E. 127th. Street, Lemont, 60439. 312-257-2265. (1)

LINCOLN: Openings for two family practitioners and one OB/GYN in central Illinois. Local hospital is a progressive 133 bed community hospital with a population base of 40,000, in a two county area. Lincoln is a hub for five major cities that have major universities, tertiary care centers, shopping, recreational and cultural activities. Contact D. David Sniff, Administrator, Abraham Lincoln Memorial Hospital, Lincoln 62656, 217-732-2161. (3)

MATTOON: Primary care physicians needed for Tri-County clinic. Attractive East Central Illinois community. Financial startup package. Access to university towns. Anesthesiologists needed for six year old 210 bed JCAH approved hospital. Send C.V. to Bill Rauwolf, SBLHC, P.O. Box 372, Mattoon 61938 (217-258-2577) (4)

MONMOUTH: Family practice physician needed immediately to assume well established practice in thriving Illinois agricultural community. 15 minutes from 91-bed JCAH accredited hospital with range of support services. Major university, private college and recreational facilities nearby. Submit C.V. to Victoria Hennenfent, Community Memorial Hospital, Monmouth, 61462 (309) 734-3141. (3)

(Continued on page 55)

Doctor's News

RESOLUTIONS DEADLINE—The ISMS House of Delegates' annual meeting will convene Friday through Sunday, April 6-8, at the Chicago Marriott hotel. Resolutions for the House of Delegates must be *received* in the ISMS offices by March 7, 1984. Those received after that date will be considered late resolutions and require special action for possible consideration.

In accord with House policy, resolutions will be published in the *Journal* by author and subject only. Resolutions which are received in the ISMS offices by an earlier deadline, February 6, will be published in the March *IMJ.*

PHYSICIANS IN THE NEWS—**Joseph McKay, M.D.,** Oak Brook, received a Stritch Medal at the Loyola University Stritch School of Medicine's annual dinner in November.

Cook County Medical Examiner, **Robert J. Stein, M.D.,** Chicago, was recently elected president of the National Association of Medical Examiners.

REHABILITATION OF CORONARY PATIENTS—The American College of Cardiology Learning Center, Bethesda, Maryland will hold a three day program, "Rehabilitation of the Coronary Patient," February 13-15, 1984. The program is designed to provide the physician with current information about the rehabilitation of patients with coronary disease.

Registration fee is $375 for members of the College and $435 for nonmembers. The program is approved for 19 Category 1 CME credit hours. For more information contact the ACC, 9111 Old Georgetown Road, Bethesda, Maryland 20814, (301) 897-5400.

AMA REPORTS REDUCED FUNDING FOR MEDICAL EDUCATION—According to a recent AMA news release, medical school physicians and administrators, feeling funding pressures, are being forced to concentrate on patient services at the expense of education. According to Leighton E. Cluff, M.D., in the December 2 issue of *JAMA,* revenue levels previously supported by federal grants are increasingly dependent on patient care funds.

INTERNATIONAL PATHOLOGY CONGRESS—The XV International Congress of the International Academy of Pathology will be held at the Fontainebleau Hilton, Miami Beach, Florida from September 3 through September 7, 1984. The program will include symposia, slide seminars, plenary lectures and scientific papers. For more information contact the Congress Secretariat, United States-Canadian Division of the International Academy of Pathology, 1003 Chafee Ave., Augusta, GA 30904, telephone (404) 724-2973.

LEGIONELLA INFECTION RISK—*Legionella pneumophila* bacterium, the organism found in water supplies, may not be killed by routine disinfection in hospital hydrotherapy tanks, according to a recent AMA news brief. In the December 9 issue of *JAMA,* Wayne Brabender, M.D. and colleagues at Kansas University Medical Center, Kansas City, wrote of the case of a 71 year old open hip wound patient who acquired *Legionella* infection after treatment in a tank that had been disinfected with povidone-iodine. The report states that patients who receive hydrotherapy for decubitus ulcers and extensive burns are also at risk. They note that hyperchlorination and superheating have been reported to be more effective agents to eradicate this organism in institutional water supplies.

NOMINATIONS SOUGHT FOR PRESTIGIOUS AWARDS—Deadline to nominate individuals for several awards of the Association for the Advancement of Medical Instrumentation (AAMI) Foundation is February 1, 1984.

The annual Laufman-Greatbatch Prize, a $10,000 endowment, will be awarded to the group or individual who has made a critical contribution to the enhancement of medical instrumentation.

Candidates may also be nominated for the Becton Dickinson Career Achievement Award, a $1000 endowment to recognize outstanding achievement by a health care professional in the development or improvement of medical devices.

Clinical engineers may be nominated for the Clinical Engineering Achievement Award, a $1000 endowment in recognition of excellence and achievement in the clinical engineering field.

In addition, the AAMI is offering the following paper awards:

The Annual Meeting Manuscript Award of $500 cash and a commemorative plaque for the best paper or manuscript in the advancement of health care technology presented at the AAMI's annual meeting; and the Student Manuscript Award of $150 cash and plaque for the most outstanding student paper presented at the AAMI annual meeting.

To obtain award brochures, contact the AAMI office: Association for the Advancement of Medical Instrumentation, 1901 N. Fort Myer Dr., Suite 602, Arlington, Virginia 22209 (703/525-4890). Completed nomination forms should be addressed to the AAMI Foundation Awards Committee at the AAMI office and questions and submissions for the manuscript awards should be addressed to "Manuscript Awards" at the AAMI office. ◀

EKG

(Continued from page 20)

Answers: 1. B, C, D 2. E

The ECG shows a sinus rhythm at a rate of 68 beats per minute. The Q waves seen in leads II, III, and AVF are the result of the fifteen year old inferior wall myocardial infarction. The T waves in leads V_2 and V_3 are tall and peaked. Hyperkalemia would be a consideration but is less likely since the tall T waves are so well localized. Serum electrolytes were normal here. These are the hyperacute T waves of acute injury and infarction. As seen here, ST segment elevation or a current of injury often accompanies the tall T waves. These are transient changes and are often followed by other electrocardiographic signs of an acute myocardial infarction. The Q-T interval is frequently prolonged. All of the treatment considerations are reasonable. The coronary anatomy was known to be severely diseased. His ischemic pain with hyperacute T wave changes was unrelieved by a combination of anti-anginal medications. The intra-aortic balloon pump was utilized and the patient was taken to triple aorta coronary bypass surgery. Postoperatively no myocardial infarction could be diagnosed by cardiac enzymes, ECG changes, or technetium myocardial scanning. He is doing well, working full time, eighteen months later.

Illinois Society, American Association of Medical Assistants

Medical Assistants' Five Year Strategic Plan

By Lesa B. Greene, CMA-C

The Long Range Planning Committee for the American Association of Medical Assistants recently unveiled a five-year strategic plan aimed at enhancing the professional status of the medical assistant. The concept of an employee who solely assists the physician in an office setting had its roots in the 1950's. However, public awareness of the profession is poor. This plan promises to utilize a public relations program which will help to educate groups about the merit of securing this versatile health care employee.

In addition, the plan calls for mandatory certification of all medical assistants and mandatory recertification for those already credentialed in order to show proof of continued competency. There are 455 medical assistants in the Illinois state society, yet only 108 are certified. Currently, you need not be certified to practice medical assisting, but according to Dot Sellars, CMA-A and chairperson of the Long Range Planning Committee, "our ultimate goal is that we want state legislatures to recognize our certification rather than state licensure as a requisite to practice."

Revalidation of certification has traditionally taken two forms: (1) examination and (2) the continuing education point method. The AAMA plan calls for development of a variety of continuing education seminars to give the medical assistant easy access to courses providing revalidation points.

As physicians you may ask how you may help support this credentialing effort. You may best demonstrate your support by:

**Hiring certified medical assistants
**Encouraging your existing personnel to become certified
**Sponsoring your assistant in attending continuing education programs
**Encouraging your assistant to belong to the AAMA

In 1982, over 200,000 people worked as medical assistants in physician offices nationwide. It is believed that the number of medical assistants will nearly double in the year to come. The traditional concept of the on-the-job trained employee will continue to be replaced by skilled workers with a background of formal study and training. It is largely through your efforts in recognizing the benefits of hiring a credentialed employee that the profession of medical assisting will be upgraded.

For further information regarding the five-year strategic plan, feel free to contact Betty Kronemeyer, CMA, president, Illinois Society, 809 North 10th Street, Mascoutah, IL., 62258, or Lesa B. Greene, CMA-C, chairman, Public Relations Committee, 8836 West Grand Avenue, River Grove, IL., 60171. ◀

Physician Recruitment

(Continued from page 52)

PARIS: Service area 30,000. Practice independently or join an established group. Openings for family practitioners, internists, general surgeons, pediatricians and OB/GYN. Modern 100 bed hospital. Liberal financial package available. Thirty miles from Terre Haute, Indiana. Varied recreational activities nearby. Contact: Thomas E. Cecconi, Administrator, Paris Community Hospital, East Court Street, Paris, 217/465-4141. (1)

SALEM: Population 7,800. 70 miles east of St. Louis, immediately off I-57. Need OB-GYN physician to join existing corporation or to practice independently. Existing corporation provides renovated office building less than five minutes from 65 bed JCAH accredited hospital. Guaranteed salary. Contact: Thomas G. Walther, Administrator, Salem Hospital, Salem, 62881. (618) 548-3194. (4)

STREATOR: Community of 22,000, serving population area of 70,000. Located 60 miles from Joliet and Peoria. Fully equipped hospital of 248 beds, with 41 physicians on staff. Cardiology, psychiatry and family practice specialities needed. Practice guarantees provided. Interested physicians are asked to send current resumes to: Terence Schuessler, Administrator, St. Mary's Hospital, 111 Spring Street, Streator 61364. (4)

Viewbox

(Continued from page 18)

DIAGNOSIS: Relapsing polychondritis with aortic insufficiency

Differential Diagnosis

All of the choices listed can cause aortic insufficiency. *Marfan Syndrome* is associated with dilation of the ascending aorta, aortic insufficiency, and aortic dissection. Patients may have myopia and ectopia lentis but do not have deformity of the nose or deafness. *Congenital syphilis* can cause "saddle" nose deformity, eighth nerve deafness and myocarditis, but not aortic disease. Acquired syphilis may, rarely, involve the nasal bones causing nasal deformity and also may cause aneurysmal dilation of the ascending aorta and aortic insufficiency. Ear involvement would be very rare. *Rheumatic heart disease* could certainly result in aortic insufficiency but not nasal deformity and bilateral deafness. *Ehlers-Danlos Syndrome* is a familial connective tissue disorder which has a variety of clinical subgroups. Joint hypermobility is characteristic. Vascular lesions include aortic aneurysm, spontaneous rupture of large vessels, and aortic dissection. Retinal detachment, blue sclera, microcornea, and ectopia lentis are found, but nasal deformity and deafness are not.

Relapsing polychondritis is a disease of unknown etiology in which there is episodic inflammation of cartilagenous tissue and special sense organs. Aortic insufficiency occurs in about 10% of patients and sometimes progresses rapidly. Nasal involvement occurs in 75% of patients and progressive hearing loss in one third. The "saddle" nose deformity is due to cartilage damage so that the indentation is inferior to the nasal bone (Fig. 2).

Aortic Insufficiency

Aortic insufficiency can be due to congenital or acquired valvular disease or disease of the aortic root. Dilation of the aortic ring and proximal ascending aorta leading to aortic insufficiency have been associated with cystic medial necrosis, idiopathic aortitis, Marfan Syndrome, osteogenesis imperfecta, syphilitic aortitis, rheumatoid arthritis, seronegative polyarthridites, giant cell arteritis, and rarely, relapsing polychondritis.[1-3]

Relapsing Polychondritis

Relapsing polychondritis is an uncommon disorder of unknown etiology characterized by episodic inflammation and degeneration of cartilage structures throughout the body.[1] Airway and skeletal lesions are often emphasized, but cardiovascular involvement is also a major cause of death and disability.[4,5]

The history of the patient presented here is typical in that she slowly developed progressive disease with multiple areas of involvement over a period of years. The diagnosis of relapsing polychondritis was not possible initially but became evident as a combination of clinical findings developed. She was well until age 32, when she developed laryngeal stridor and was found to have laryngeal edema. She was given antibiotics and gradually improved. Six months later she was noted to have a right sided hearing loss. A year later, she developed exophthalmos due to left orbital pseudotumor and was also found to have anterior uveitis. She was treated with steroids which resulted in improvement. She was referred to a rheumatologist when arthralgias developed, and relapsing polychondritis was suspected as her primary diagnosis. Over the next year deformities of both ears (Fig. 3) and the nose developed (Fig. 2), and deafness became bilateral. The diagnosis of relapsing polychondritis was made and she was maintained on 25mgm of prednisone daily. Six months prior to admission, she was noted to have a diastolic murmur of aortic regurgitation and a blood pressure of 105/50mmHg. There were no symptoms related to the cardiovascular system. She came to the emergency room six months later in severe cardiac failure. Following resuscitation, there were murmurs of aortic and mitral insufficiency.

After transfer to the cardiac intensive care unit, she was maintained on nitroprusside infusion. Echocardiography showed evidence of severe aortic insufficiency. She was taken to surgery and the aortic valve was replaced. At surgery the mitral valve was normal. The aortic root was relatively small, but the aortic annulus was dilated. The aortic leaflets were thin, and there was a pinpoint fenestration of the left coronary cusp. On subsequent histologic examination, the aortic valve leaflets were normal, but there was minimal lymphocytic infiltration of the aortic ring. One year following aortic valve replacement, she has no cardiovascular symptoms.

Diagnosis[1,2]

The diagnosis of relapsing polychondritis is based primarily on its unique clinical features and is established when three or more of the following[1] are present: (a) bilateral auricular chondritis, (b)

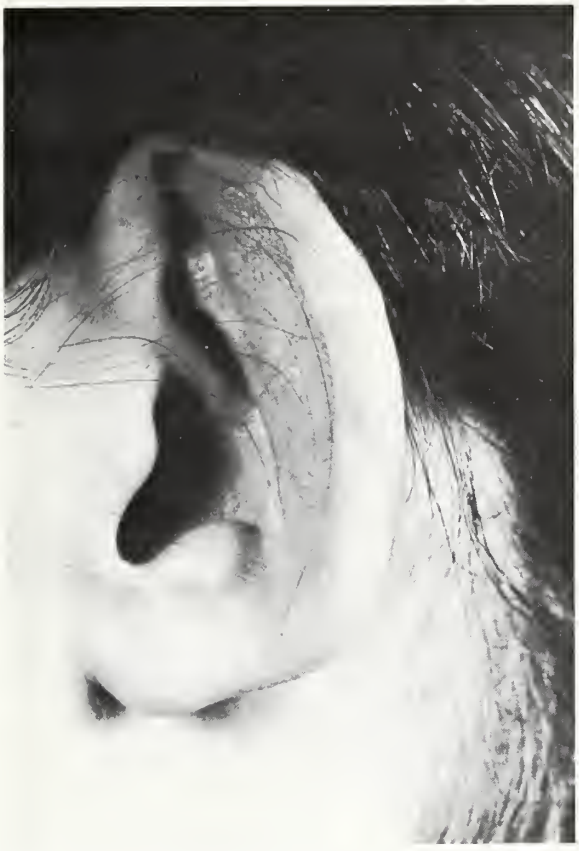


FIGURE 3
Floppy outward protruding ear in a patient with relapsing polychondritis. The other ear was also effected. (Photo courtesy of Herbert Rubinstein, M.D.)

nasal chondritis, (c) nonerosive seronegative inflammatory polyarthritis, (d) ocular inflammation, (e) respiratory tract chondritis, and (f) audiovestibular damage. About one third of patients have a preceding or coexisting autoimmune disease.

(A) *Auricular Chondritis (90%)*

The external ear is the most common site of the disease. It is noteworthy that some patients may be first seen because of acute or episodic pain and swelling of the ears with no evident disease elsewhere in the body. The cartilagenous portions of the external ears (helix, antihelix, tragus, external auditory canal) are usually involved bilaterally. Early in the course of the disease there is swelling, redness, and pain lasting 1-2 weeks and subsiding spontaneously. After repeated episodes, cartilage damage often results in a cauliflower ear, droopy pinna, or floppy protruding ears. Soft tissue calcification may be visible on radiographs.

(B) *Nasal Chondritis (75%)*

Signs and symptoms related to nasal chondritis may be the first manifestation of disease. The nose may be acutely inflammed, red, and tender. Occasionally there is epistaxis. The late outcome is a "saddle nose" with an indentation below the nasal bone as a result of collapse of the nasal cartilage. Congenital syphilis, Wegener's granulomatosis or focal infection may cause a similar nasal contour.

(C) *Arthritis (75%)*

The joint symptoms are usually asymmetric, transient, and involve the upper and lower extremities including the hands and feet. Arthritis is usually nonerosive. There may be arthralgias only. The parasternal joints and costochondral junctions are often involved. Articular symptoms may occasionally be a presenting problem. Monoarticular arthritis, sacroiliitis and erosive arthritis have all been reported. A combination of arthritis and conjunctivitis may suggest Reiter's Syndrome.

(D) *Ocular Inflammation (60%)*

The conjunctiva, cornea, sclera, or uvea may be involved. Conjunctivitis and episcleritis are the most frequent problems. Exophthalmos, as found in the patient reported here, is relatively rare.

(E) *Respiratory Tract (55%)*

Patients may develop involvement of the epiglottis, larynx, trachea, or bronchi. Early symptoms include hoarseness, wheezing, stridor, and dyspnea. Later destruction of tracheal and bronchial cartilage may lead to obstructed airways. Secondary pneumonia is common and respiratory involvement is the most common cause of death in patients with relapsing polychondritis. Areas of tracheal narrowing, sometimes focal but usually diffuse, can be seen on radiographs. Respiratory tract lesions may be the initial manifestation of the disease, as in the patient presented here.

(F) *Audio-Vestibular Dysfunction (50%)*

Vertigo, ataxia, nausea, or vomiting indicate vestibular involvement which may be unilateral or bilateral. Tinnitus and progressive hearing loss occur in about one third of patients. Hearing loss is primarily due to cochlear damage but is contributed to by eustachian tube obstruction, occlusion of the external auditory canal by inflammation, and inflammation of the middle ear.

Cardiovascular Lesions

Cardiovascular lesions occur in about 25% of patients with relapsing polychondritis. Cardiac arrhythmias, conduction defects, myocarditis, valvular disease, and pericarditis have been reported along with aortic aneurysm, aortic dissection, and vasculitis of large and medium sized vessels.

Aortic insufficiency in a patient with relapsing polychondritis was first reported in 1966.[6] At least 13 patients have been reported since that time. It has been estimated that about 10% of patients with relapsing polychondritis will develop aortic insufficiency.[3] This patient is only the third reported female with this complication.[7] This is surprising since relapsing polychondritis affects men and women equally. The time interval from the diagnosis of relapsing polychondritis to the onset of aortic insufficiency has varied from three months to 17 years.[1,3,6] Insufficiency is usually progressive, requires surgery, and has been noted to progress rapidly in some patients.[8] Aortic insufficiency in patients with relapsing polychondritis is almost always the result of dilation of the aortic ring due to inflammation of its supporting connective tissue. Most patients who have had surgery have been found to have normal aortic cusps and dilation of the aortic ring.[1,3,8] In one review, 3 of 12 patients had thickened cusps, but the thickening was felt to be due to hemodynamic stresses rather than a primary abnormality.[3] A single case was reported in which cusps were destroyed while the aortic ring was undilated. This patient later developed dilation of the ascending aorta which required reoperation.[7]

Prognosis

Relapsing polychondritis may occur at any age, but the mean age of reported patients is about 40 years. As of 1976, 159 patients with relapsing polychondritis had been reported.[9] In one review, 29/136 patients died after a median survival of about five years.[2] Most of the remaining patients had a low grade course lasting for many years. Corticosteroid therapy was generally successful in controlling symptoms, sometimes with very low doses.[2] Cytotoxic drugs have also been useful in the therapy of steroid-resistant disease.

The unique combination of clinical findings in this disease usually indicates the diagnosis. Airway involvement is the most common cause of death, followed by cardiovascular involvement. Patients should be examined carefully for evidence of valvular insufficiency which may progress rapidly, as in the patient presented here.[1,3]

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

February

Diabetes

Current Concepts in Diabetes Mellitus
For: MD's, RN's & dieticions. Lecture. Feb. 10-11, Urbana. **Sponsor:** Carle Foundation Hospital, Department of Medical Education, 611 West Park St., Urbana 61801. **Fee:** $100.00 (Sat. only $35.00) **Reg. Deadline:** Feb. 3. **Credit:** AAFP Elective, 10.5 hours, AMA Category 1, 10.5 hours. **Contact:** Deborah C. Rugg. **Phone:** 217/337-3022.

Medicine

Medicine Grand Rounds
For: MD's. Lecture, Wednesday, 11:30-12:15pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 1 hour. **Contact:** Dr. Ben B. Blivaiss, 312/578-3215.

Practice Management

Choosing and Using a Computer in a Private Medical Practice
Lecture, Feb. 10-11, 8:00-5:00pm, Las Vegas. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295.00. **Credit:** AMA Category 1, 16 hours. **Contact:** Dr. Ben B. Blivaiss **Phone:** 312/578-3215.

Practice Management

Choosing & Using a Computer in a Private Medical Practice
Lecture, Feb. 24-25, 8am-5pm, Atlanta, Georgia. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295.00. **Reg. Limit:** none. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivaiss, MD **Phone:** 312/578-3215.

Gastroenteralogy

Gastroenterology Symposium
For: MD's. Symposium, Feb. 3, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** Yes. **Reg. Limit:** None. **Credit:** Category 1, TBA. AAFP Prescribed, TBA. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medical Education

Evaluation of Clinical Competence
Workshop, Feb. 9-10, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** Yes. **Reg. Limit:** Max. TBA. **Credit:** Category 1, TBA. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Family Medicine

Medical Seminar-At-Sea
For: MD's. Seminar, Feb. 18-March 5, Panama Canal. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** Yes. **Reg. Limit:** None. **Credit:** Category 1, 66 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Neuralogy

Basic Science of Neurology
For: Neurologists, Psychiotrists. Lecture, Feb. 20-24, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood. St., Chicago 60612. **Fee:** $450.00. **Reg. Limit:** Max. 90. **Credit:** Category 1, 42 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Surgery

Review Course of Neurological Surgery
For: Neurosurgeons, Neurologists, Lecture, Feb. 3-12, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675.00. **Reg. Limit:** None. **Credit:** Category 1, 101 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Surgery

Specialty Review in Pediatric Surgery
For: Surgeons. Lecture, Feb. 6-9, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390.00. **Reg. Limit:** None. **Credit:** Category 1, 36 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Family Practice

Advances in Family Practice
For: MD's. Lecture, Feb. 13-17, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390.00. **Reg. Limit:** Max. 150. **Credit:** Category 1, 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

March

Licensure

State & National Board Review, Clinical
For: MD's taking state licensure exams. Lecture, Mar. 26-31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510.00. **Reg. Limit:** Max. 90. **Credit:** Category 1, 56 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Licensure

State & National Board Review, Basic
For: MD's taking State Licensure Exams. Lecture, Mar. 19-25, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510.00. **Reg. Limit:** Max. 90. **Credit:** Category 1, 62 hours. **Contact:** Robert J. Baker, MD **Phone:** 312/733-2800.

Dermatology

Pediatric Dermatology
For: MD's. Lecture, Mar. 19-21, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $280.00. **Reg. Limit:** Max 55. **Credit:** Category 1, 21 hours. **Contact:** Robert J. Baker, MD **Phone:** 312/733-2800.

Psychiatry

Specialty Review in Psychiatry
For: Psychiotrists & Neurologists. Lecture, Mar. 12-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480.00. **Reg. Limit:** Max 55. **Credit:** Category 1, 45 hours. **Contact:** Robert J. Baker, MD **Phone** 312/733-2800.

Psychiatry

Comprehensive Psychiatry Review Part I: Basic Considerations
For: Psychiotrists. Course, Mar. 12-17, Chicago. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, 60637. **Fee:** $450. **Reg. Limit:** None. **Credit:** Category 1, 42 hours. **Contact:** Mary Ann Dillon **Phone** 312/962-1056.

Medicine

Seizure Symposium
For: MD's. Symposium, March 16, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA. AAFP Prescribed, TBA. **Contact:** Lorraine Stephenson **Phone:** 217/782-7711.

Medicine

Choosing & Using a Computer in a Private Medical Practice
Lecture, March 23-24, 8am-5pm, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295.00. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Dr. Ben B. Blivaiss. **Phone:** 312/578-3215.

Surgery

Visiting Professor Lecture Series
For: MD's Lecture, Mar. 14, 8am-5pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivoiss, M.D. **Phone:** 312/578-3215.

Ophtholmology

8th Annual Ophtholmology Current Concepts Seminar '84
For: Ophtholmologists & RN's. Conference with workshops, March 22-24, Madison, Wisconsin. **Sponsor:** University of Wisconsin, School of Medicine, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** none. **Credit:** Category 1, TBA. **Other:** UW-Extension, Continuing Education Units, TBA. **Contact:** Sorah Aslakson. **Phone:** 608/263-2856.

Pulmonary Diseases

3rd Annual Symposium on Chronic Obstructive Pulmonary Diseases
For: MD's, PT's. Symposium, Workshops, Mar. 8-9, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** none. **Credit:** Category 1, TBA **Other:** UW-Extension, Continuing Education Units, TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856

Coronary Artery Disease

Recent Advancement in Treatment of Coronary Artery Disease
For: MD's. Symposium, March 8, 1pm-5pm, DuQuoin, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, 62708. **Fee:** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours, AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephensen **Phone:** 217/782-7711.

Family Medicine

Medical Seminar-At-Sea
For: MD's. Seminar, March 15-25, Caribbean Sea. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 36 hours. **Contact:** Lorraine Stephensen. **Phone:** 217/782-7711.

Pathology

Hormonal Pathology of the Endometrium
For: Pathologists & Clinical Chemists. Symposium, Mar. 19 at 7:00 pm, Chicago, Drake Hotel. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central Ave., Chicago, 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, M.D., S.C. **Phone:** 312/626-4300 ext. 5720.

Practice Management

Choosing & Using a Computer in a Private Medical Practice
Lecture, Mar. 9-10, 8am-5pm, San Antonio, Texas. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295.00. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivoiss, M.D. **Phone:** 312/578-3215.

April

Practice Management

Choosing and Using a Computer in a Private Medical Practice
For: MD's. Lecture, Apr. 13-14, 8am-5pm, Atlantic City. **Sponsor:** University of Health Sciences/The Chicago Med. Sch., 3333 Green Bay Road, North Chicago. **Fee:** $295. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivoiss, M.D. **Phone:** 312/578-3215.

Anesthesiology

Specialty Review in Anesthesiology
For: Anesthesiologists. Lecture, Apr. 29-May 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, 60612. **Fee:** $590. **Reg. Limit:** None. **Credit:** Category 1, 54 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Rehabilitation

10th National Conference on Case Resolution of the Industrially Injured
For: MD's, Therapists. Conference, Apr. 26-27, Paper Valley Hotel, Appleton, Wisconsin. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA, University of Wisconsin-Extension CEU's, TBA. **Sponsor:** University of Wisconsin-Ext., CME, 465b WARF Bldg., 610 Walnut St., Madison, 53705. **Contact:** Sorah Aslakson. **Phone:** 608/263-2856.

Radiology

Specialty Review in Radiology
For: Radiologists. Lecture, Apr. 2-6, Chicago. **Sponsor:** Cook County Graduate Sch. of Med., 707 South Wood St., Chicago, 60612. **Fee:** $450. **Reg. Limit:** None. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Urology

Specialty Review in Urology
For: Urologists. Lecture, Apr. 2-7, Chicago. **Sponsor:** Cook County Graduate Sch. of Med., 707 South Wood. St., Chicago, 60612. **Fee:** $510. **Reg. Lim:** None. **Credit:** Category 1, 53 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312/733-2800.

Gynecology, Oncology

Current Management of Problems on Gynecology and Gynecologic Oncology
For: Gynecologists, Oncologists. Course, Apr. 13-14, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, 60637. **Fee:** $195, res. $100. **Reg. Lim:** None. **Credit:** Category 1, 9 hours. **Contact:** Mary Ann Dillon. **Phone** 312/962-1056.

Endocrinology

Clinical Endocrinology Conference
For: Endocrinologists. Course, Apr. 14, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, 60637. **Fee:** TBA **Reg. Lim:** None. **Credit:** Category 1, 7 hours. **Contact:** Mary Ann Dillon, **Phone:** 312/962-1056.

Pathology

Selected Topics in Surgical Pathology
For: Pathologists & MD's. Lecture, Apr. 2-6, 8am-5pm, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison, Chicago, 60612. **Fee:** TBA. **Reg. Lim:** None. **Credit:** Category 1, 32 hours. **Contact:** Linda Mays. **Phone** 312/738-1336.

Pathology

Cytology of Condulomo & Cervical Intraepitheliol Neaplasia
For: Pathologists & Clinical Chemists. Symposium, Apr. 9, 7:00 pm, Chicago, Drake Hotel. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central, Chicago, 60644. **Fee:** Yes. **Reg. Lim:** None **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312/626-4300 ext. 5720.

Pathology

The Myeloproliferative Disorders: A Multidisciplinary Approach
For: Pathologists. Lecture, Apr. 23-27, 8am-5pm, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison, Chicago, 60612. **Fee:** TBA. **Reg. Lim.:** None. **Credit:** Category 1, 33.5 hours. **Contact:** Linda Mays. **Phone:** 312/738-1336.

Pathology

Specialty Review in Pathology: Anatomic
For: Pathologists. Lecture, Apr. 23-28, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, 60612. **Fee:** $480. **Reg. Lim:** 90. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD **Phone** 312/733-2800.

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Pathology

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Surgery

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For: MD's Lecture, Apr. 14, Chicago. **Sponsor:** Cook County Grad. Sch. of Med., 707 S. Wood, Chicago, 60612. **Fee:** $125. **Reg. Lim.:** 75. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Advanced Peripheral Vasculor Surgery
For: MD's Lecture, Apr. 16-20, Chicago. **Sponsor:** Cook County Grad. Sch. of Med., 707 S. Wood, Chicago, 60612. **Fee:** $390. **Reg. Lim.:** 90 **Credit:** Category 1, 34 hours. **Contact:** Robert Baker, MD **Phone:** 312/733-2800.

Surgery

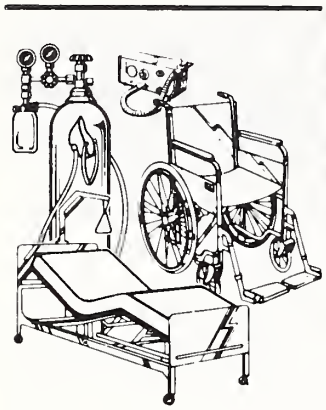
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For: MD's Lecture, Apr. 18, 8am-5pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago. **Fee:** None. **Reg. Lim.:** None. AMA Category 1, 2 hours. **Contact:** Ben B. Blivoiss, MD. **Phone:** 312/578-3215.

Medicine

Fiberoptic Colonoscopy
For: MD's Lecture, Apr. 25-27, Chicago. **Sponsor:** Cook County Grad. Sch. of Med., 708 S. Wood, Chicago, 60612. **Fee:** 450. **Reg. Lim.:** 20 **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD **Phone:** 312/733-2800.

Medicine

Fiberoptic Esophagogastric Endoscopy
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References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCAROIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PRDCAROIA CAPSULES are supplied in bottles of 100 (NOC 0069-2600-66), 300 (NOC 0069-2600-72), and unit dose (10x10) (NOC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Changing Physician Payment Systems



I see the changing physician payment systems as one of the fastest growing issues that the membership of the Illinois State Medical Society will face in the current year and for an indefinite period of time. A large number of major purchasers of medical care and payors for medical care under the existing usual, customary and reasonable payment system have identified this change as a need. Probably more significantly, if they have not felt it to be a need, they have seen it as a method to get a discount. They have assumed the prerogative of determining what is "reasonable" in the UC and R equation.

Let me first dissect UCR for you. Initially, physicians promoted the concept of usual, customary or reasonable as indicating that the peer group in a practice area was knowledgeable of the usual and customary fees charged within that area. Further, the concept implied that they recognized the expertise among their colleagues, when a reasonable increase in charges for a particular medical care delivery was a reasonable deviation. I project that as a basis for the peer review concept that went into the original UC or R.

Subsequent to the establishment of this principle, there has been a subtle change to the use of the word *and* from the use of the word *or*. To me, this has signified that the determination of what has been reasonable has shifted from that of what is usual in the practice area to what the payor—be he third party government agency or employer—perceives to be reasonable. I submit that this principle of UCR is still appropriate as a payment system for those who understand its significance and do not let it have a negative impact on quality of care or accessibility of care.

Contrasted to this there is the indemnity type of payment. I believe that we need to have a clarification of our meaning of this term. We are not referring to the dictionary definition of "indemnify," which means to compensate for loss or expenses with a connotation of totality to the reimbursement. Instead, we are referring to indemnity (as more frequently used in the insurance industry) to identify a schedule of benefits to provide the insureds with a level of reimbursement for expenses. I suggest that these definitions be kept in mind when considering changes in physician payment systems.

The second combination of issues which are closely related are those which refer to the *option* to accept assignment versus *mandatory* assignment and participation versus non-participation. The former most frequently brings up the issue of payment by assignment or non-acceptance of assignment in the Medicare reimbursement system. The latter refers to that which many of the private carriers in the health insurance industry and some payors in governmental agencies other than federal wish to implement as their method of changing the payment system. We all were aware of the efforts in Washington to change assignment last year. We were definitely put on notice that this issue will again be brought before the Congress during the coming session. Obviously, physicians must be willing to share with their elected representatives their knowledge about how this possibly could affect the quality and accessibilty of medical care to the senior citizen population of this nation. The latter issue of participation versus non-participation has an equivalent potential for taking the physician out of the decision making process when it comes to the determination of reasonable fees for the delivery of medical care.

I do not intend that this scenario be fear provoking but hope it will have some educational value. I wish to generate interest among the membership to be involved in the dialogue that will be carried on during the next years as these issues are determined. Our policy is that we believe in a pluralistic system for the delivery of medical care. I suggest that the need now exists for us to establish a companion pluralistic system for the payment of medical care. The initial ingredients of this should include the physician and/or his organizations in the determination of an agreed structure. ◀

Robert P. Johnson, M.D.

Robert P. Johnson, M.D.
President

JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

Unique, once-daily formulation providing comprehensive cardiovascular protection

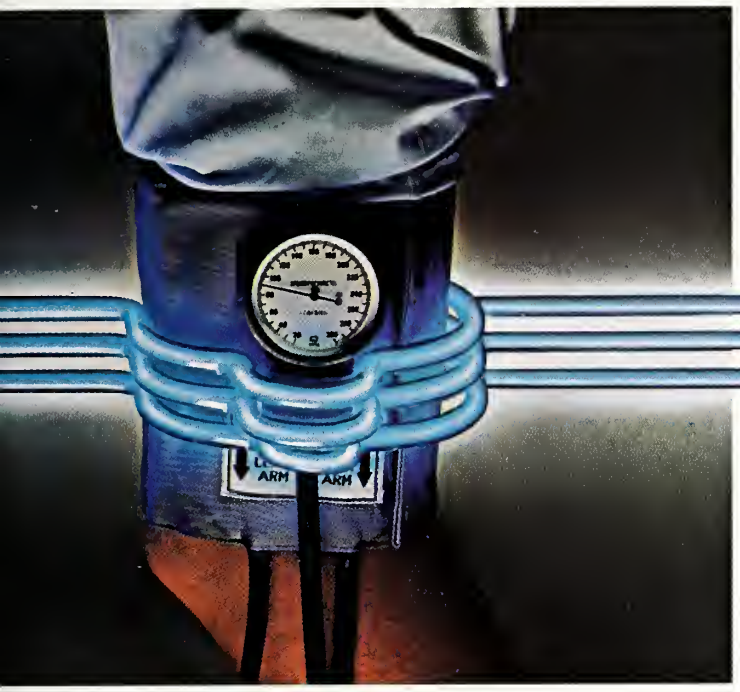
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL–with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



THE ONE™ TO COUNT ON

Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

ONCE-DAILY

INDERAL® LA (PROPRANOLOL HCl)

LONG ACTING CAPSULES

Ayerst®

The one to count on for HYPERTENSION, ANGINA and prevention of MIGRAINE.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)*
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia; LE-like reactions; psoriasiform rashes; dry eyes; male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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New York, N.Y. 10017

EDITORIAL

Evolution

Change for the sake of change is rarely productive, but failure to act when the situation warrants is inexcusable.

The ISMS Publications Committee, which initiated the sweeping changes you see in this month's *Journal,* and I, as chairman, would like to share some of the reasons for *IMJ*'s new look.

We physicians know that the science of medicine has changed over the years, but we may not realize that the art of publishing also changes in order to communicate more effectively.

Editorials by Dr. J. William Roddick, Jr., chairman of *IMJ's* editorial board, have emphasized ISMS' commitment to keep the *Journal's* clinical content relevant to the physicians of the State. The new format is offered by the Publications Committee in keeping with the latest advances in communications technology to make *IMJ* a more effective communications vehicle.

The new look, including the improved color and photo reproduction in recent *IMJ* issues, has been made possible by the use of sophisticated laser equipment that has become an integral part of printing technology. Our switch to a new printer has improved quality and, at the same time, reduced costs.

As physicians and publishers, we are well aware that the demands of medical practice often leave too little time for the physician to spend with the volume of current medical literature. The Publications Committee is well aware that *IMJ* competes with many other medical magazines for the physician's time. We hope that our new format will be a welcome change and helpful to our readers.

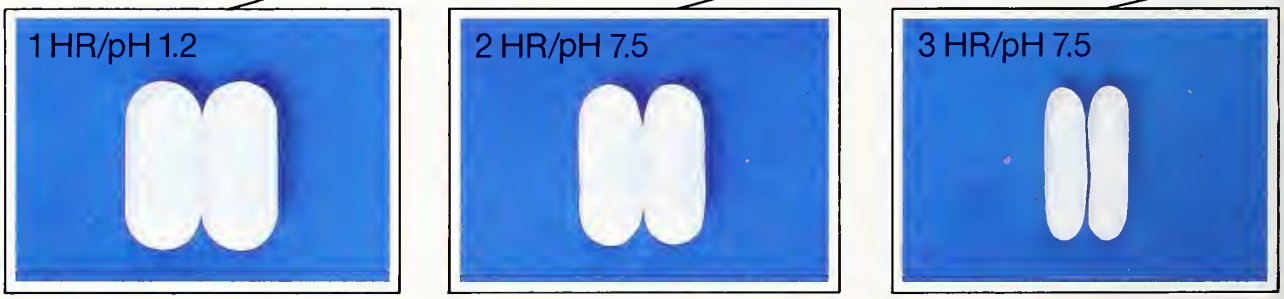
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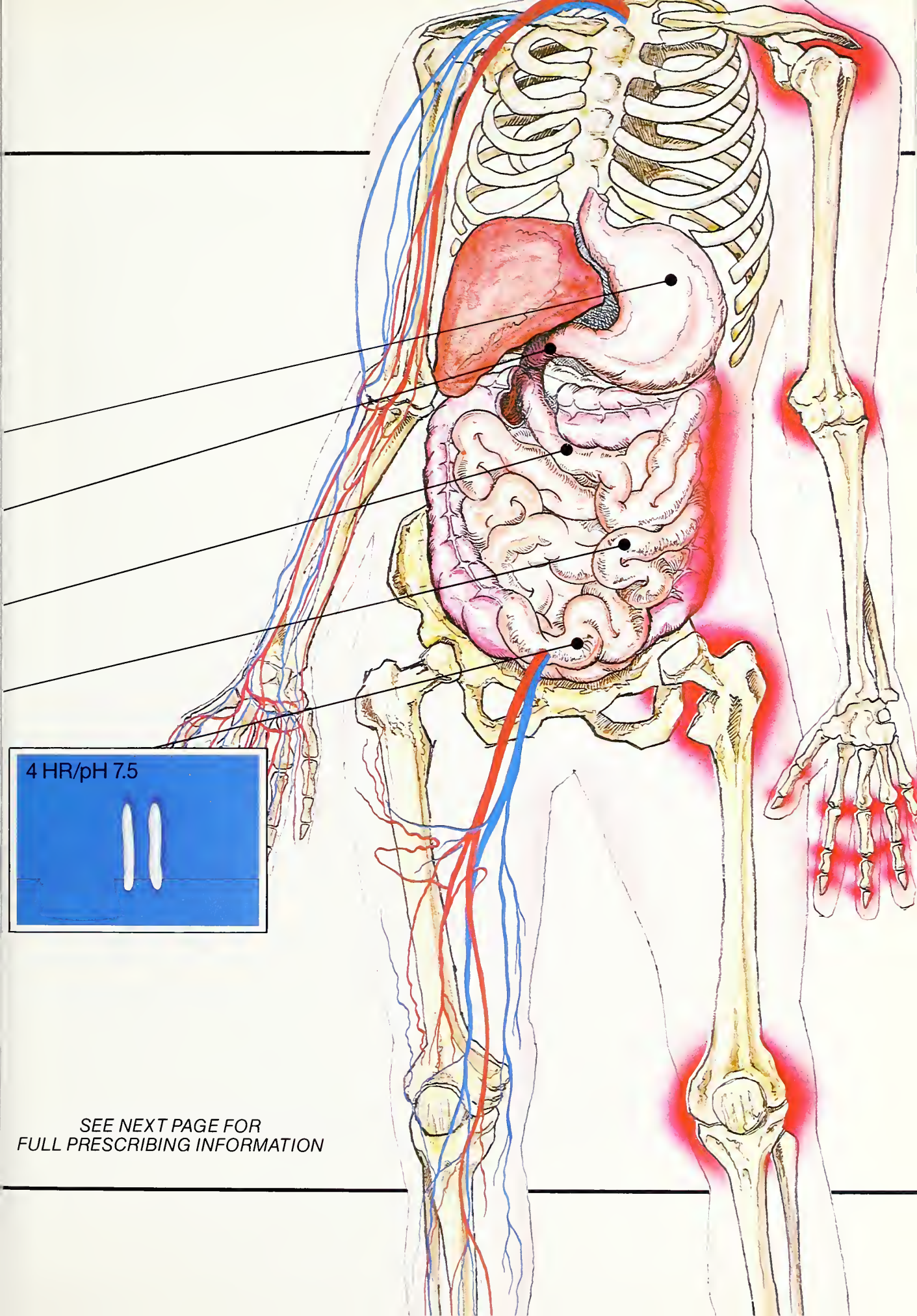


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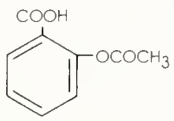


SEE NEXT PAGE FOR
FULL PRESCRIBING INFORMATION

ZORprin (ASPIRIN) Zero-Order Release

DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release; the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. □ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. □ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions; whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. □ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). □ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. □ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%); salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). □ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). □ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. □ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. □ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). □ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** □ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. □ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. □ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. □ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin has produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. □ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. □ Aspirin should not be taken during the last 3 months of pregnancy. □ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. □ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. □ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. □ Salicylates can produce changes in thyroid function tests. □ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. □ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. □ **Drug Interactions:** (See **WARNINGS**) Aspirin may interfere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. □ Aspirin may enhance the activity of methotrexate and increase its toxicity. □ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. □ **Pregnancy Category D.** See **WARNINGS** Section. □ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. □ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anti-coagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. □ **Gastrointestial:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. □ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. □ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, e.g. slow-reacting substance of anaphylaxis. □ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. □ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. □ **Renal:** Aspirin rarely may aggravate chronic kidney disease. □ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. □ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsines, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants; salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. □ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) □ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact.* □ *Breaking the tablets or disrupting the structure will alter the release profile of the drug.* □ *It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* □ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. □ **Zorprin is not recommended for children below the age of 12.** □ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. □ Bottles of 100 Tablets—NDC 0524-0057-01. □ **Caution:** Federal law prohibits dispensing without prescription. □ U.S. Patent No. 4,308,251. □ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.**

The structural formula of aspirin is:



12/8/83 0057-04

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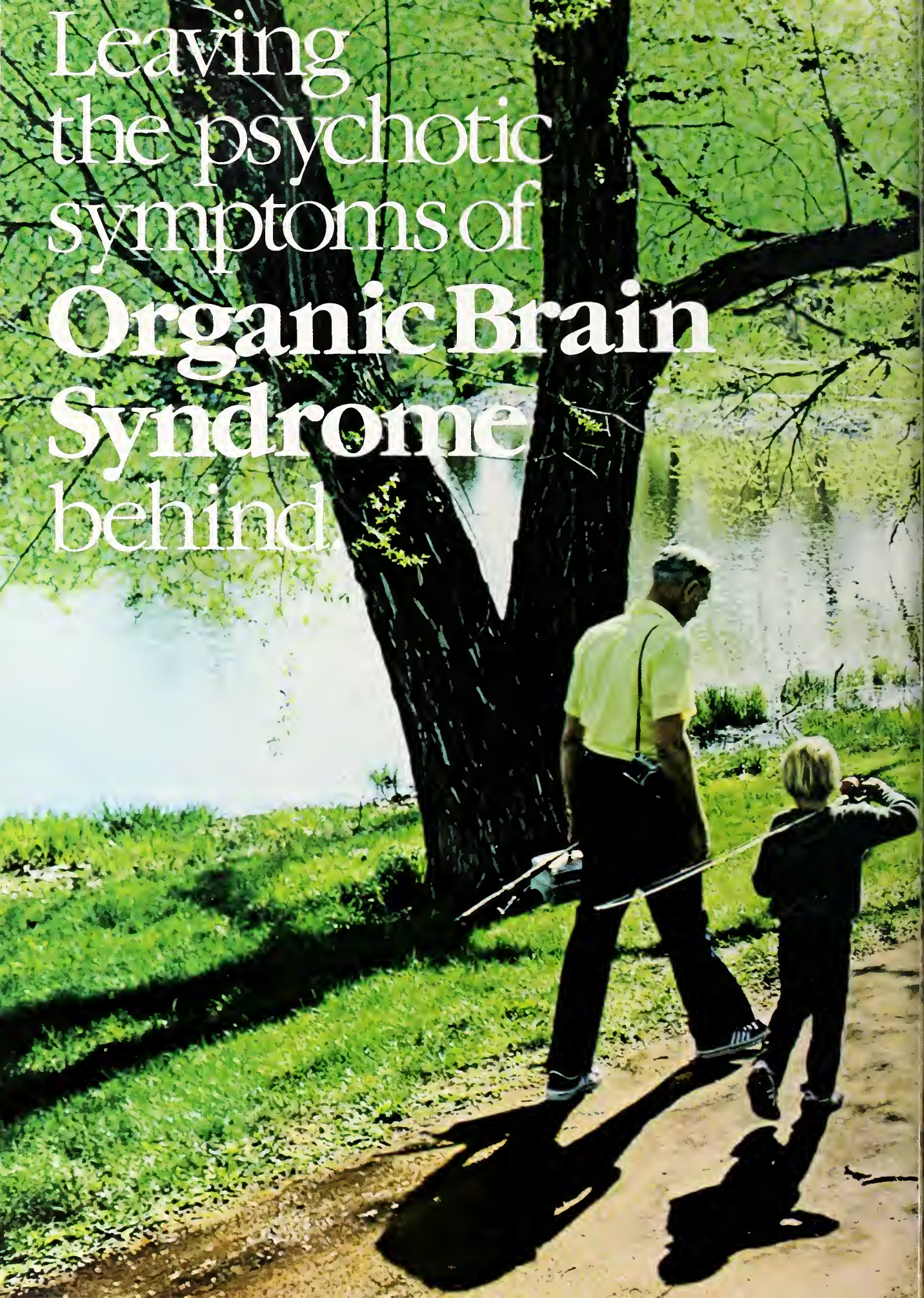
About twenty years ago, a Louisville, Kentucky, internist suggested that America's 16th President, Abraham Lincoln, was suffering from Marfan's syndrome. Since that time controversy has raged over the validity of that diagnosis, with adamant supporters on each side.

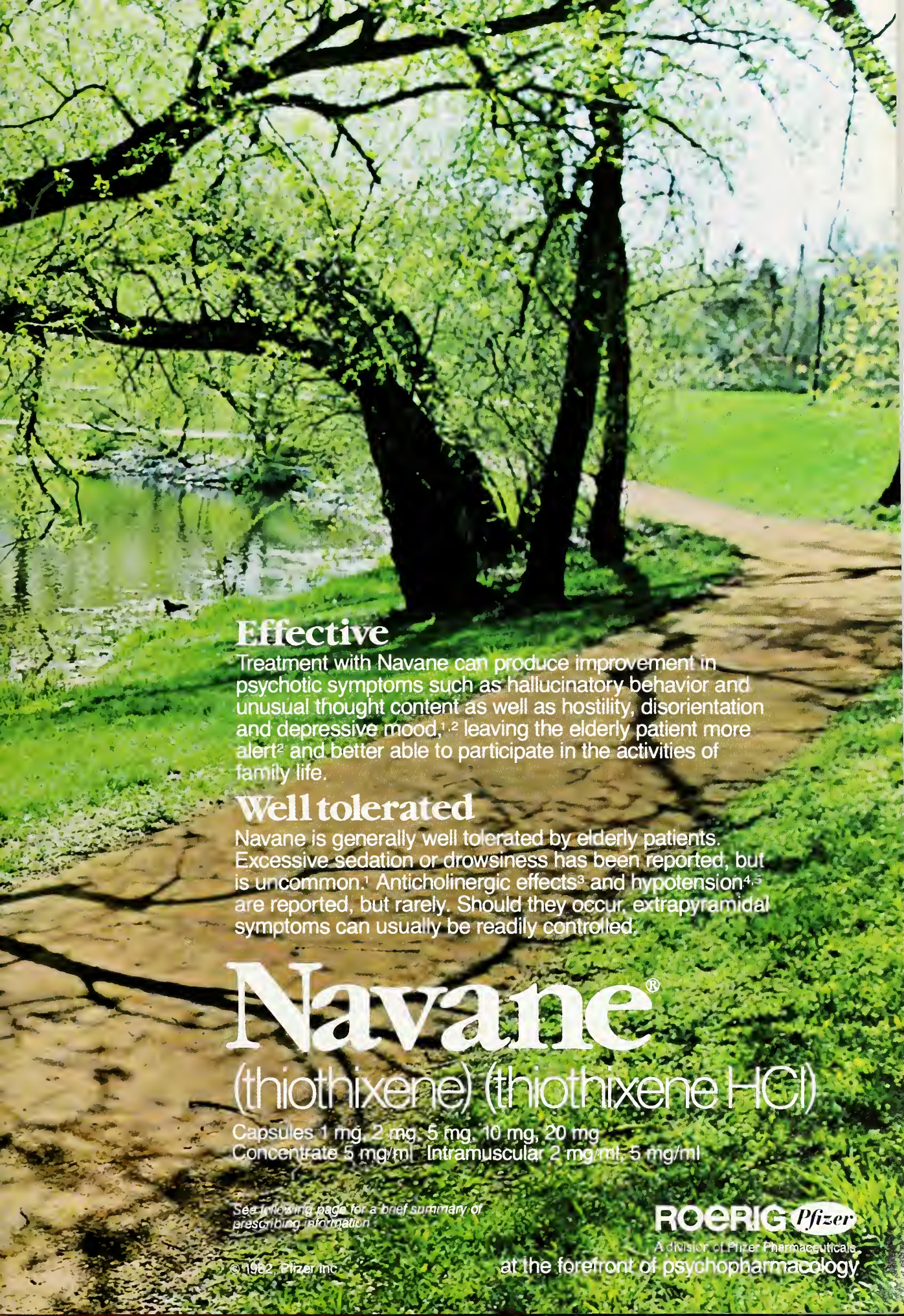
Those who feel that Lincoln did indeed suffer from Marfan's syndrome base their diagnosis on his size, long legs and arms, and anecdotal stories of his various periods of illness. Utilizing photographs and historical documents, these individuals are convinced that Mr. Lincoln did indeed suffer from this condition. It was even suggested by some that all four of Lincoln's sons exhibited Marfan's traits, and that the three who died in childhood did so of this disease. On the other side are the stories of Lincoln's prodigious strength and physical abilities, as well as casts of his hands which show them to be too muscular for those of a Marfan's patient. It was asked how the strongest young man living in New Salem, Illinois, could be suffering from a disease which debilitates its victims.

Given Lincoln's central Illinois heritage, it is altogether fitting that another method of diagnosing Marfan's syndrome would be discussed by authors from Springfield, Lincoln's home. This month, as we celebrate the 175th anniversary of his birth, we have an article on that subject. The authors describe echocardiographic changes in patients with previously undiagnosed Marfan's syndrome. They discuss two patients with cardiac abnormalities typical of Marfan's syndrome, both of whom had a family history of the condition, but neither of whom had been so diagnosed. In addition, seven other living family members were identified as having definite Marfan's syndrome on the basis of physical examination and characteristic echocardiographic abnormalities.

It is interesting to speculate whether or not a definite diagnosis of Marfan's syndrome might have been made on President Lincoln had current technology been available at that time. Of course, had the question been answered one way or another, we would just have had to find something else on which to speculate concerning this great President.

J. W. Roddick, Jr., M.D.
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Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

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Navane®
(thiothixene) (thiothixene HCl)

References: 1. Util-TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM. Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R. Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM. Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml

Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.

Warnings: *Usage in Pregnancy*— Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children— The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration— As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions. *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

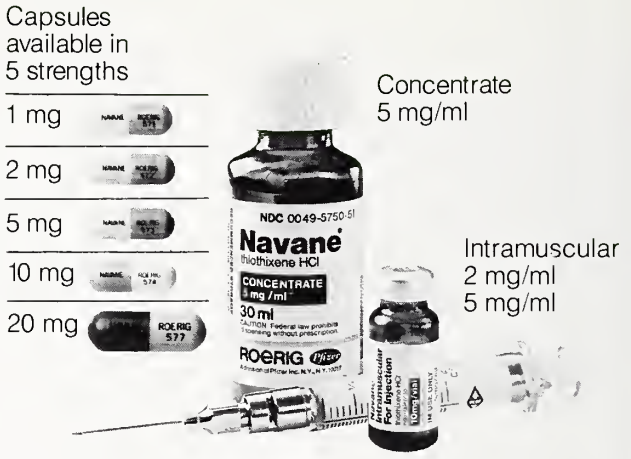
CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia; hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection— Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules. Navane Concentrate— In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

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Obituaries

***Bochenek, Andrzej,** Evanston, died November 14, 1983 at the age of 27. Dr. Bochenek was a 1981 graduate of *Akademia Medyczna,* Krakow, Poland.

***Lerner, Louis S.,** Lincolnwood, died December 23, 1983 at the age of 73. Dr. Lerner was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

***Lutz, J.Frederick,** Sturgis, died November 7, 1983 at the age of 73. Dr. Lutz was a 1931 graduate of Rush Medical College, Chicago.

****Mahoney, Joseph M.,** Oak Lawn, died January 2, 1984 at the age of 78. Dr. Mahoney was a 1931 graduate of Loyola University Stritch School of Medicine, Maywood.

***Ploplys, Valentinas,** Rockford, died December 8, 1983 at the age of 69. Dr. Ploplys was a 1940 graduate of *Vyteuta Didziojo Universiteto Medicinos Fakelteto,* Kaunas, Lithuania.

***Schaefer, C. Michael,** W. Dundee, died December 6, 1983 at the age of 62. Dr. Schaefer was a 1951 graduate of Loyola University Stritch School of Medicine, Maywood.

***Schlunk, Franz, F.,** Palos Heights, died December 16, 1983 at the age of 54. Dr. Schlunk was a 1955 graduate of *Medizinische Fakultat der Phillipps Universitat,* Marburg/Lahn, Hessen, Germany.

Sprechner, Herman C., Evansville, died September 24, 1983 at the age of 76.

***Suhs, Edwin P.,** Chicago, died December 12, 1983 at the age of 30. Dr. Suhs was a 1978 graduate of the University of Health Sciences/Chicago Medical School.

****Ulrich, Henry J.,** Ellisville, died December 1, 1983 at the age of 84. Dr. Ulrich was a 1924 graduate of Washington University School of Medicine, St. Louis.

****Wagner, Arthur S.,** Chicago, died December 21, 1983 at the age of 85. Dr. Wagner was a 1924 graduate of *Schiesische-Friedrich-Wilhelms-Universitat Medizinische Fakultat,* Berlin, Prussia, Germany.

****Walton, William H.,** Lenzburg, died December 2, 1983 at the age of 77. Dr. Walton was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

***Williams, Victor,** Los Gatos, California, died October 6, 1983 at the age of 80. Dr. Williams was a 1934 graduate of Northwestern University Medical School, Chicago.

***Zaldivar, Raul A.,** Oak Park, died November 5, 1983 at the age of 60. Dr. Zaldivar was a 1948 graduate of *Facultad de Ciencias Medicas de la Universidad de Buenos Aires,* Argentina.

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Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

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References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PRDCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PRDCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PRDCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PRDCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PRDCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

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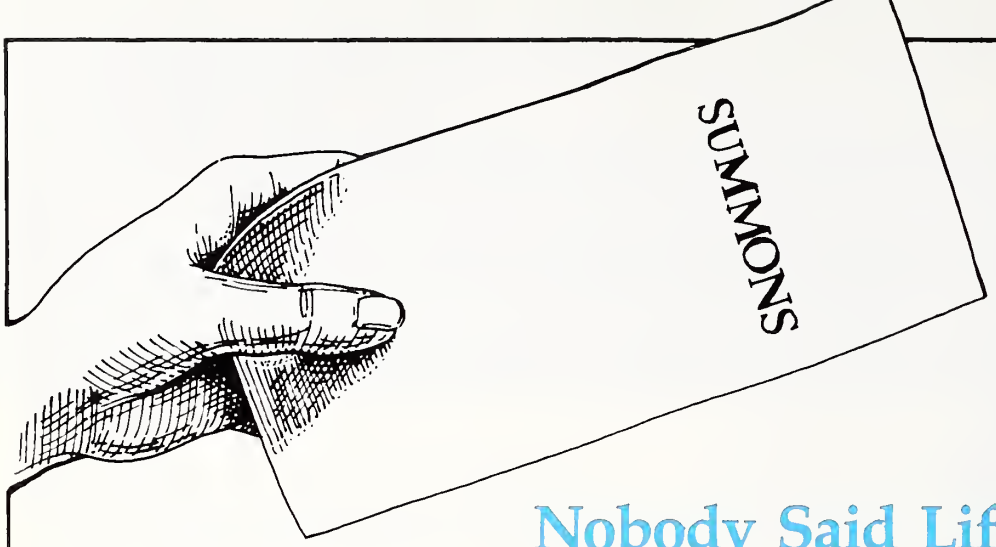


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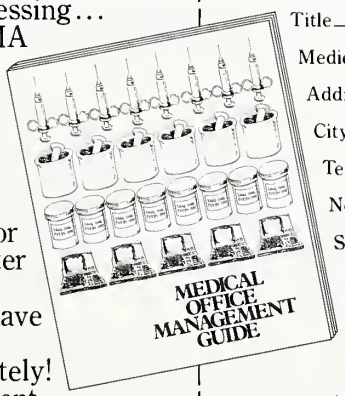
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Additional NMR information on page 136

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Echocardiography in the Diagnosis of Marfan's Syndrome

By Roger Fulton, M.D., H. Weston Moses, M.D., Wilfred Lam, M.D., Joel A. Schneider, M.D. And Harry A. Wellons, M.D./Springfield

Marfan's syndrome is a genetic disorder of connective tissue with abnormalities of the skeletal, ocular and cardiovascular systems.[1,2] Although the skeletal abnormalities comprise the most conspicuous features of the disease, the cardiovascular lesions account for the life threatening complications of the Marfan's syndrome.[3] Aortic dilation with rupture or dissection cause the majority of early deaths. These patients often present acutely without a prior diagnosis of Marfan's syndrome. With the increasing availability of echocardiography, a non-invasive method of identifying patients with aortic dilatation and possible dissection is now available.[4-6] We recently used echocardiography to diagnose two patients who presented with acute aortic dissection. Both patients underwent emergency surgery for aortic valve replacement and repair of the dissection.

Case one was a 25 year old white male, admitted with a three day history of mid-sternal chest pain radiating to his upper back. He had no known prior history of heart disease, and he did not carry the diagnosis of Marfan's syndrome. However, he stated that his father had died at age 32 of a "ruptured aorta". Physical examination revealed the patient to be barrel-chested with long spider-like fingers. Height was 6′-1″ and arm span was 6′-7″. He had a high arched palate. Blood pressure was 120/50 in the left arm and 90/50 in the right arm, pulse 96, respirations 24. Carotid upstrokes were brisk. A Grade III/VI diastolic decrescendo murmur was present at the left sternal border and a soft systolic murmur at the upper left and right sternal borders. Lung fields were clear.

Admission laboratory values were normal. ECG demonstrated slight ST segment elevation in lead 1 and in the inferior and lateral precordial leads. Chest X-ray revealed the heart size to be at the upper limits of normal but was otherwise unremarkable. Echocardiography was performed on admission (Figure 1A). The aortic root was markedly dilated to 6cm. in diameter (normal 2.0-3.7cm.). An extra echo was present along the posterior wall of the aortic root, which was typical for a tear in the aortic root. Aortic regurgitation was demonstrated by fluttering of the anterior leaflet of the mitral valve during systole. Left ventricle chamber size at end diastole was mildly enlarged at 6.0cm. diameter (normal 3.5-5.7cm.) but contractility was normal. After the echocardiogram was completed the patient underwent cardiac catheterization which confirmed the dilated aortic root seen on the echocardiogram. It also demonstrated severe aortic regurgitation and evidence of Type One aortic dissection. The patient was taken to the operating room and underwent emergency aortic valve replacement and repair of the aortic dissection. The patient had an uneventful postoperative recovery and was discharged from the hospital 10 days later.

Case Two

A 43 year old white male was admitted who reported anterior chest pain and shortness of breath. Upon arrival, a blood pressure of 80 was obtained and an aortic insufficiency murmur noted. Before physical examination could be completed he suffered a cardiac arrest. A family history of Marfan's syndrome with several occurrences of sudden death was obtained from the patient's wife, although she had

FIGURE 1A
Longitudinal view of the aortic root in Case I. The aortic root is markedly dilated and a flap is visualized.

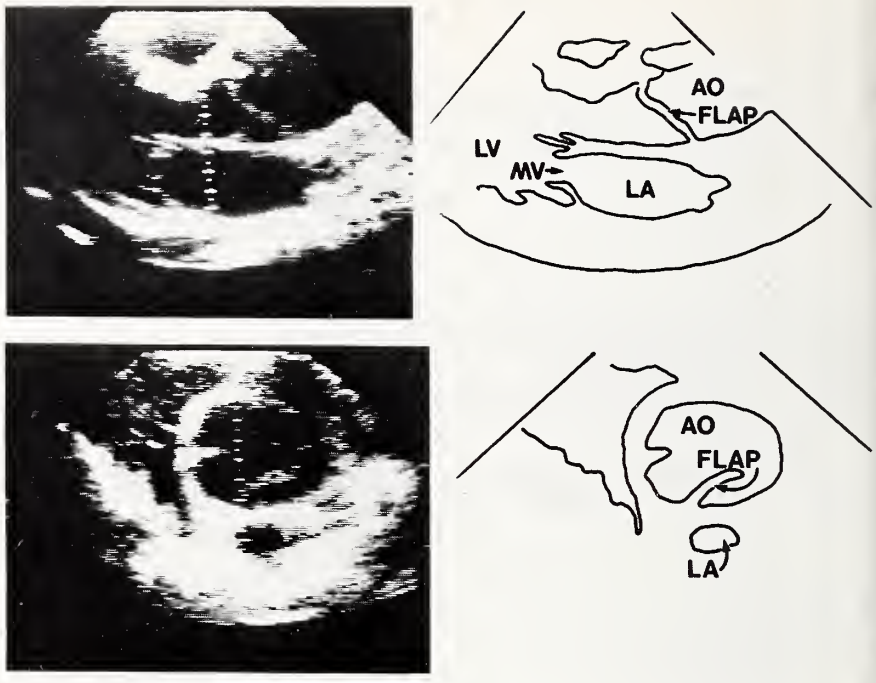


FIGURE 1B
Cross sectional view of the aortic root in Case II. The aortic root is markedly dilated and a flap is visualized.

FIGURE 1
In both A and B the flap was better seen on the real-time study since the fluttering or waving motion of the flap is lost on the still photograph. LV = left ventricle, Ao = aorta, MV = mitral valve, LA = left atrium

believed that her husband was not afflicted. The patient was found to be a second cousin of the patient described in Case One.

During resuscitation an emergency bedside echocardiogram was performed (Figure 1B) which revealed a markedly dilated aortic root with evidence of an intimal flap seen in the aortic root. The left ventricle was mildly dilated but contractility appeared normal. After a 50 minute resuscitation, including insertion of a temporary transvenous pacemaker and administration of pressor agents, relatively stable rhythm and blood pressure were obtained and the patient was taken to the operating room where he had successful hemodynamic repair of a Type One dissecting aortic aneurysm. The patient did not undergo cardiac catheterization prior to surgery. Unfortunately, the patient had suffered irreversible brain damage during the prolonged cardiac resuscitation, remained comatose one month following surgery, and was then transferred to an extended care facility.

Further detailed family history revealed that definitely four other family members (and possibly two others) had died suddenly due to acute dissecting aortic aneurysm. Seven living family members were identified as having definite Marfan's syndrome on the basis of physical examination and characteristic echocardiographic abnormalities.

Discussion

Marfan's syndrome is not a common disorder but it does not appear to be a rare entity in Illinois, either. Although we have no specific data on the incidence of Marfan's syndrome here, seven other members in the family of the two patients described have now been identified as having Marfan's syndrome. We know anecdotally of other families in central Illinois with Marfan's syndrome.

When patients present with the usual clinical features, the diagnosis of Marfan's syndrome can be made fairly easily. A positive family history is helpful but 15% of cases are believed due to spontaneous mutations. Therefore family history may be negative. Also, Marfan's syndrome is an autosomal dominant disorder; variable gene penetrance occurs and affected individuals may present with acute dissecting aortic aneurysm and only subtle skeletal features suggestive of Marfan's syndrome.

In both cases presented, the diagnosis of aortic dissection was made by echocardiography. In Case Two, the patient was sent to surgery with the diagnosis of acute aortic dissection based solely on clinical presentation and echocardiographic findings. Normally, we prefer that confirmation of the diagnosis is made by aortography. However, the patient was too acutely ill to allow further studies. Echocardiographic features of dissection are summarized in Table 1.

The diagnosis of Marfan's syndrome in the asymptomatic individual is made on the basis of typical features noted on routine physical examination. Additional aid in making the diagnosis can be obtained by slit lamp exam of the eyes (looking for dislocated lens) and by echocardiography. On echocardiography the patients have an increased incidence of mitral valve prolapse and dilated aortic root.[4] Aortic regurgitation is sometimes present. No biochemical test exists for the diagnosis of Marfan's syndrome, although obviously biochemical abnormalities must exist to account for the cystic medial necrosis present in the aorta.

Table 1
Echocardiographic Features of Aortic Dissection

I. Findings which are often associated with aortic dissection, but must be evaluated in the individual clinical context since they may occur without dissection:
 A. Widening of the posterior or anterior aortic wall or both.
 B. Parallel motions of the linear echoes of the widened aortic root wall.
 C. Significant aortic root dilation of 42 mm or more (upper limits of normal is usually 37mm).
 D. Fluttering of the mitral valve leaflet during diastole indicating aortic regurgitation.
II. Actual visualization of the intimal flap on the 2-D echocardiogram is not always possible but is the most specific finding.

The physician is faced with the problem of management of patients with asymptomatic Marfan's syndrome and documented aortic dilitation. No controlled studies exist as to the best management, but lifetime therapy with beta-blocking drugs to reduce the occurrence of aortic dissection has been advocated.[8] We have adopted this approach in several family members of the patients discussed. If marked dilitation of the aortic root is noted, prophylactic repair of the aneurysm of the ascending aorta may be warranted.

Summary

We have presented two patients from a family afflicted by Marfan's syndrome, who presented with acute dissecting aortic aneurysms. In both cases, the initial diagnosis was made on the basis of physical appearance and echocardiography. In one case, surgery was performed based solely on the clinical presentation and echocardiographic findings. Since their presentation, several members of their family have been identified as having Marfan's syndrome with dilated aortic roots and are being treated with long term beta-blocker therapy to reduce the risk of aortic dissection. ◀

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Roger Fulton, M.D., is a third year resident physician at the SIU School of Medicine, Springfield. He is presently completing rotations at Memorial Medical Center and St. John's Hospital.

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In a Patient with a Heart Murmur

Unsuspected Aortic Valve Vegetation

By Brian Cohen, M.D., George J. Taylor, M.D., Donald R. Graham, M.D., and Robert E. Myers, M.D./Springfield and Clinton

Routine echocardiography in patients with valvular heart disease may reveal unsuspected pathology.[1,2] We describe a patient, referred for aortic stenosis, who was found unexpectedly to have a mass on the aortic valve suggesting infective endocarditis despite the absence of symptoms or laboratory findings of endocarditis[3,4].

A 54 year old woman had a five year history of severe obstructive lung disease. She had required hospitalization twice in the previous five months. The present admission resulted from increasing dyspnea, fatigue, palpitations and a single episode of syncope. A murmur of aortic stenosis was noted and she was referred for cardiac catheterization. Other medical history included a subendocardial infarction five years before.

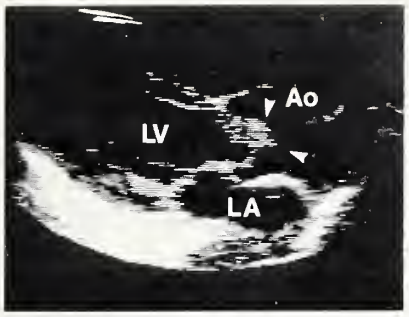
During the preceding 12 months she had received six separate courses of antimicrobial therapy for either purulent sputum or dysuria. Therapy included four separate five day courses of ampicillin, 500mg. four times a day, a five day course of doxycycline 50mg. twice daily, and a seven day course of cephalexin 250mg. four times a day.

She was an emaciated woman who appeared to be chronically ill. Her temperature was 37.2°C. Anterior-posterior diameter of the chest was increased; breath sounds were distant and diffuse rhonchi were audible. Her precordium was hyperdynamic with a forceful left ventricular impulse. The second heart sound split physiologically and the first heart sound was normal. A systolic ejection murmur was audible at the left sternal border and right base, and it radiated to the carotid arteries. In addition, there was a soft, diastolic decrescendo murmur. Her carotid upstroke was normal. Femoral and pedal pulses were diminished. No peripheral edema was detected.

Her white blood count was 8,300 with a slight left shift. Hemoglobin was 18.6g/dl. Electrocardiogram showed sinus rhythm with left axis deviation, left atrial enlargement and T wave changes consistent with left ventricular hypertrophy. Chest X-ray showed minimal cardiomegaly and hyperlucent lungs. Her forced vital capacity was 2.22 L. and her forced expiratory volume at one second was severely reduced at 240 ml. (28% of predicted).

The echocardiogram (Figure 1) showed normal left ventricular size, function and thickness. The two-dimensional echocardiogram demonstrated a 2cm. mass connected to the right coronary cusp of the aortic valve and extending to the wall of the aorta. Excursion of that leaflet was markedly reduced when compared with other leaflets, which were thin and mobile. Because of the apparent vegetation on the aortic valve, a presumptive diagnosis of endocarditis was made. After six blood cultures were obtained she was treated with methicillin and tobramycin. Blood cultures were negative for bacteria and fungi. Cultures for rickettsia, brucella and chlamydia also were negative. Because of negative cultures therapy was stopped after 10 days. Her fatigue and mild dyspnea persisted. After one week off antimicrobial therapy, six more blood cultures were obtained and incubated for four weeks. Brucella titers, compliment fixation titers for Q fever, histoplasma, toxidiomycosis, blastomycosis and chlamydia all were normal.

To evaluate the possibility of non-bacterial, marantic endocarditis associated with a malignancy, the patient had barium studies of the gastrointestinal tract, an intravenous pyelogram, abdominal sono-



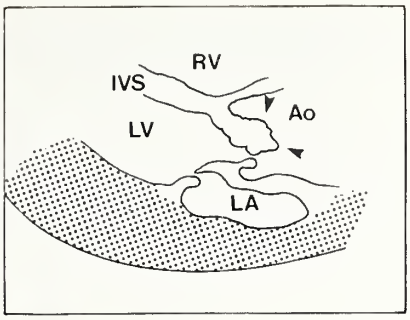


Figure 1: LA = left atrium, Ao = aorta, RV = right ventricle, IVS = interventricular septum, LV = left ventricle.
Two-dimensional echocardiogram in a parasternal, long axis view demonstrating the large vegetative mass on the aortic valve leaflet (arrows).

graphy and computed tomography of the abdomen, all of which were normal.

While blood cultures for rickettsia were pending, she was treated with tetracycline 2gm per day. These cultures remained negative and tetracycline was stopped after four weeks. There has been no change in her clinical status during tetracycline therapy or the four months following treatment. Exercise tolerance has not improved and dyspnea persists.

Echocardiogram was repeated three months following the initial study. The vegetation on the aortic valve was unchanged. Left ventricular size and thickness remained normal.

Discussion

This case demonstrates the importance of echocardiography in routine evaluation of heart murmurs even when catheterization is planned. The patient was referred for angiographic evaluation of aortic stenosis. Symptoms and physical examination were consistent with this diagnosis. Pre-catheterization detection of the mass in the aortic root was unexpected but of great importance because it enabled her to avoid a potentially dangerous procedure. Manipulation of cardiac catheters near valvular vegetations, cardiac tumors or intracavitary thrombi may result in dislodgement and embolization.[5]

A further benefit of the echocardiogram in this patient was better assessment of hemodynamic status. The normal left ventricular size, good systolic function and normal wall thickness excluded hemodynamically significant aortic stenosis. The echocardiogram also showed no significant valvular obstruction despite the vegetation. Two of three aortic valve leaflets moved normally. The source of her systolic murmur may have been the mass lesion, which limited excursion of the third cusp and produced turbulence. Furthermore, a repeat echocardiogram three months after initial evaluation showed no change in left ventricular size, function or thickness. This excluded persistent, excessive hemodynamic overload.

The etiology of aortic valve mass in this patient has not been proven by tissue diagnosis. By far the most common cause of such lesions is infective endocarditis.[2-4] However, blood cultures for both bacteria and fungi were negative. In addition, she had no peripheral signs of endocarditis, such as embolus or nephritis, and she remained stable over a four month period of observation.[5-7]

Endocarditis may have occurred sometime before her present evaluation. She had received six courses of antibiotics for exacerbations of bronchitis or dysuria. A short course of antibiotics may have eradicated a highly susceptible organism causing endocarditis.[8] Persistence of the valvular vegetation does not exclude this possibility. Stewart, *et al.*, observed that 92% of patients successfully treated for endocarditis had persistent vegetations after bacteriologic cure. Some patients had no change in vegetations for as long as three years after successful therapy.[4] Vegetations on a valve do not invariably mean active endocarditis but may instead reflect healed endocarditis.

Cardiac masses may be caused by primary tumors, but these are quite unusual in the aortic root.[9] A more common neoplastic source for valvular masses is marantic endocarditis with tumor vegetation of the valve.[10] Search for a primary tumor was negative. Her stable clinical course since initial evaluation is inconsistent with either metastatic carcinoma or active infection.

Should our patient have her aortic valve replaced? The presence of vegetation identifies patients at increased risk for peripheral embolization, valve disruption and heart failure,[5] even after eradication of active infection. However, a vegetation alone is not an indication for surgery. Heart failure due to valvular disruption and possible peripheral embolus remain the prerequisites for valve replacement in bacterial endocarditis. This is true regardless of the presence or absence of vegetations.[4-5]

The usual role of the echocardiogram in endocarditis is to support the diagnosis in patients with that clinical syndrome. We have described a patient who had no clinical evidence for endocarditis but that possibility was raised by abnormal echocardiogram. This noninvasive study helped her avoid cardiac catheterization. ◀

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Viral Hepatitis Serologic Diagnosis and Prophylaxis

BY YU-WEN CHANG, M.D./RANDALLSTOWN, MARYLAND

Viral hepatitis is one of the most serious infectious diseases in the United States. Each year, about 55,000 cases are reported to the Center for Disease Control and there may be ten times that many subclinical infections. It is a growing problem for patients and staff in hemodialysis units, hematology-oncology units, operating rooms and clinical laboratories. But it is also a serious public health concern.

The differentiation among types A, B, and non-A, non-B (NANB) viral hepatitis (Table 1) is important clinically as well as epidemiologically because morbidity, mortality, immunoprophylaxis and prognosis vary with the type. In the past few years, there have been rapid and significant advances in the understanding of viral hepatitis with the development of specific serologic tests. In many cases, the differential diagnosis can be made from the history, clinical picture and epidemiological features (Table 2). Serologic tests are necessary for a definitive diagnosis.

Structures of Hepatitis Viruses

Interpretation of the serologic tests, especially those for hepatitis B (HB), is aided by an understanding of the structure of the viruses. Hepatitis A virus (HAV), a picornavirus, measures 27nm in diameter. The virion contains single-stranded RNA in the center, surrounded by a protein capsid with 32 capsomers (Figure 1). HAV may be demonstrated in the stool and blood of patients with acute hepatitis A (HA).

Hepatitis B virus (HBV) is a 42-nm, double-shelled spherical particle, once known as the Dane particle. The outer-envelope protein is the HB surface antigen (HBsAg), which can appear freely and is easily detectable in blood or other body fluids as 22nm spheres or elongated tubules of variable lengths. Within the outer envelope is the 28nm dense core, with core antigen (HBcAg) on its outer nucleocapsid and circular double-stranded DNA and DNA polymerase inside. Because HBcAg is sequestered within HBsAg-bearing virions, freely circulating HBcAg is not detected in serum.

The exact nature and location of the e antigen (HBeAg) is uncertain, but it is believed to be present in the core and probably is part of the HBcAg.

HA is endemic throughout the world. Population surveys in the United States have indicated a prevalence of antibody to HAV (anti-HAV) greater than 30%. The rate is closely related to age and socioeconomic factors. Persons older than 50 years are four times more likely to have anti-HAV than those younger than 20 years. The antigen is three times more common in lower socioeconomic classes than in middle and upper classes. Institutional-

FIGURE 1
Structure of the Hepatitis Viruses

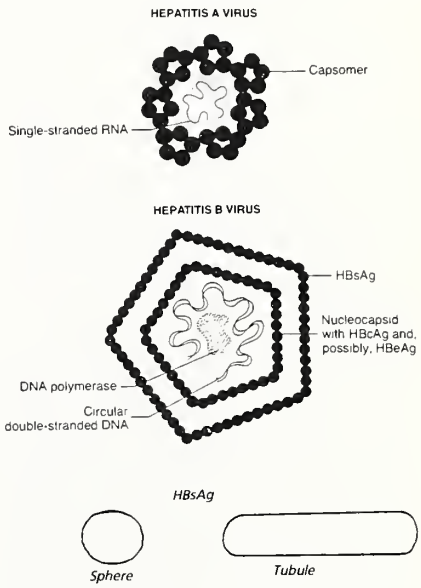


Table 1
A Glossary for Viral Hepatitis

Hepatitis A	**(Epidemic hepatitis, infectious hepatitis, short-incubation hepatitis).**
HA	Hepatitis A
HAV	Hepatitis A virus
HAAg	Hepatitis A antigen
*Anti-HAV	Antibody to HAV; can be IgG or IgM
Hepatitis B	**(Homologous serum hepatitis, long-incubation hepatitis).**
HB	Hepatitis B
HBV	Hepatitis B virus (formerly called Dane particle)
*HBsAg	Hepatitis B surface antigen (Australian antigen, HAA).
*Anti-HBs	Antibody to HBsAg
HBcAg	Hepatitis B core antigen
*Anti-HBc	Antibody to HBcAg; can be IgG or IgM (Serologic test for IgM anti-HBc is not routinely available).
*HBeAg	Hepatitis B e antigen
*Anti-HBe	Antibody to HBeAg
Non-A, Non-B Hepatitis	**(Post-transfusion hepatitis)**
NANB	Non-A, non-B hepatitis, a diagnosis of exclusion; caused by a group of viruses that have not yet been characterized.

**Serologic marker for which a test is available for clinical use.*

Note: Viruses other than the hepatitis viruses—Epstein-Barr virus and cytomegalovirus, for example—can produce many of the findings of viral hepatitis. Their main manifestations are extrahepatic, however, and by definition they do not produce viral hepatitis.

ized people and children at day care centers are at increased risk of HA, as are the close household contacts of acute HA patients. The infection is spread via the anal-oral route, mainly through contaminated food or water.

HBV also has a worldwide distribution. The high frequency of chronic carrier states (they occur in 5% of people infected with HBV) facilitates the spread of the virus. The prevalence of HB serologic markers is over 15% in this country. The rate is closely related to socioeconomic, age, and geographic factors. The route of infection is parenteral, primarily via contact with blood or other body fluids. As a result, multiply transfused patients, those receiving chronic dialysis, hemophiliacs, newborns, homosexual men, IV drug abusers, healthcare professionals, and the sexual partners of HB patients are at especially high risk.

Serologic detection of HA and HB has demonstrated that up to 25% of cases of acute sporadic viral hepatitis and up to 90% of cases of post-transfusion hepatitis are NANB. Contaminated blood is the main source of this parenterally transmitted infection. The high incidence of chronic infection and chronic carrier states, and the absence of specific markers, makes NANB a tremendous public health concern, particularly in blood donor screening. In addition to multiply transfused patients, those receiving chronic dialysis, hemophiliacs, and IV drug abusers are at increased risk.

Typical Course of Viral Hepatitis

It is important to know the typical sequence of events in viral hepatitis in order to select serologic tests in suspected cases and interpret the results correctly. The schematic representations of the markers that might be found in serial samples from patients with acute HA, acute HB, and chronic HB appear in Figure 2.

Symptoms of HA develop 15 to 45 days after exposure. HAV is shed in stool for about two weeks before and two weeks after the onset of symptoms. The virus may also be present in blood, but its presence has not been well documented. As symptoms appear, IgM anti-HAV develops; it reaches its peak in two to three weeks. This antibody may be detectable up to 12 weeks after the onset of illness. A second antibody, IgG anti-HAV, appears after the acute period and is usually detectable for the rest of the patient's life.

The incubation period of HB is 30 to 180 days. HBsAg is usually positive anywhere from three weeks to four months after exposure and several weeks before the onset of clinical symptoms. It peaks shortly after the onset of symptoms and disappears within one to two months. HBeAg appears within one week after the detection of HBsAg. Antibody to HBcAg (anti-HBc) appears around the time symptoms appear (sometimes earlier) and rapidly rises in titer. It may persist for many years or life. If antibodies to HBeAg and HBsAg (anti-HBe and anti-HBs) have not yet appeared, anti-HBc may be the only serologic marker detectable. This phenomenon is called the "core window." It typically lasts two to six weeks.

Shortly before the disappearance of HBeAg, anti-HBe becomes detectable; it may persist for months after the clearance of HBsAg. The interval between the disappearance of HBsAg and the appearance of anti-HBs, the last marker to appear, may be present for years or indefinitely.

Half of all HBV infections are subclinical and self-limited. Another 40% follow the course described above. Thus, 90% of infections confer permanent immunity to further HBV infection. But HB differs from HA in that it may lead to chronic liver disease, chronic carrier states and hepatocellular carcinoma. In 10% to 15% of cases, patients develop chronic HB or a chronic carrier state. HBsAg and HBeAg persist for over six months, and anti-HBe and anti-HBs do not develop. Of these patients, 30% will develop cirrhosis or hepatocellular carcinoma. They need repeated testing for surface antigens and antibody. Some may eventually show clearance of HBeAg and the appearance of anti-HBe, (seroconversion) which indicates pending

TABLE 2
Differential Features of Viral Hepatitis

	HA	HB	NANB*
Virus	27 nm, RNA	42 nm, DNA	Unknown group of viruses
Incubation period (mean)	15-45 days (30 days)	30-180 days (60 days)	15-150 days (45 days)
Patient age	≤30 yr	All ages	Primarily adults
Onset	Abrupt	Insidious	Insidious
Symptom rate	33%	50%	50%
Clinical severity	Usually mild	Often severe	Less severe
Jaundice	50%	30%	20%
High fever	Common	Uncommon	Uncommon
Serum sickness	Uncommon	Common	Uncommon
Duration of illness	Short	Long	Variable, with fluctuating course
Duration of infectivity	Short	Long	Long
Isolation	Enteric isolation	Blood precautions	Blood precautions
Prognosis	Very good	Variable	20% cirrhosis
Chronic infection	None	10%-15%	20%-40%
Carrier state	None	5%	10%
Recovery	99%	85%	Variable
Mortality	0.1%	1%-3%	1%-2%
Treatment	Supportive	Supportive, ? steroids	Supportive
Prophylaxis	Immune globulin (IG)	HB immune globulin or IG vaccine	? IG

**Many features of NANB lie between those of HA and those of HB, but in general NANB resembles HB more closely than it does HA.*

resolution of infection and improvement of liver status.

Indication and Selection of Tests

Tests for the serologic markers are ordered: (1) to make a specific diagnosis in patients with clinical and laboratory evidence of acute or chronic hepatitis; (2) to evaluate the progression of disease and prognosis of patients known to have viral hepatitis; (3) to evaluate asymptomatic patients for infectivity or carrier status; (4) to determine the immune status of exposed people or those at risk of exposure and (5) to identify candidates for immune prophylaxis or HB vaccination.

If the clinical situation is clear, it is not necessary to order every available test. Since immunity is determined by the presence of IgG anti-HAV and anti-HBs, for example, these are the only tests required to determine a patient's immune status. In general, for screening purposes (of blood donors, for instance) the only marker looked for is HBsAg. When the population to be screened is at high risk, however, anti-HBc and anti-HBe may be added to identify asymptomatic carriers.

A practical approach to the diagnosis of acute viral hepatitis is presented in Figure 3. The diagnosis can be made by testing for IgM anti-HAV, HBsAg, and anti-HBc.

Most patients with acute viral hepatitis show complete recovery within six months after onset of symptoms. Patients with prolonged clinical HB should have monthly tests for HBsAg, HBeAG, and anti-HBs until HBsAg becomes negative. While seroconversion from HBeAg to anti-HBe means improvement, the appearance of anti-HBs is essential to be sure of complete recovery, loss of infectivity, and immunity.

NANB viruses and HBV, but not HAV, are implicated in many cases of chronic hepatitis. As with acute disease, many other causes of hepatitis, such as drugs and various collagen-vascular diseases, must be ruled out. Stepwise serologic testing for chronic hepatitis is outlined in Figure 4.

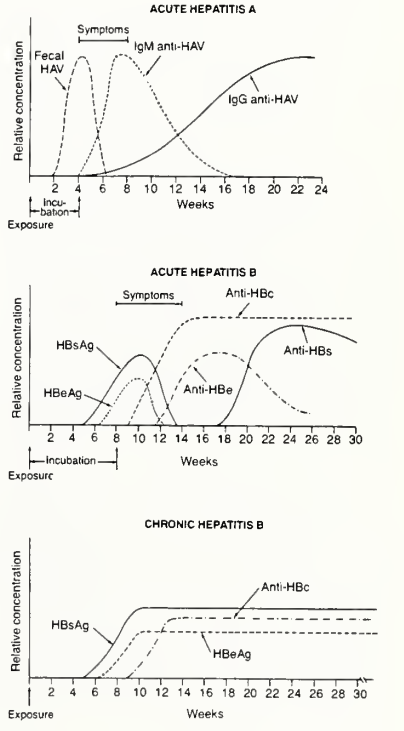
Significance of the Markers

Serologic profiles can aid clinicians in the differential diagnosis of viral hepatitis (Table 3). However, certain considerations should be kept in mind.

First, the diagnosis of acute hepatitis should rest on the combination of a compatible clinical history, physical examination, and typical lab findings. It is very important to know when the specimen was collected in relation to the patient's clinical picture and liver function.

Next, a negative result cannot completely rule out the disease in question.

FIGURE 2
Sequence of Serologic Events



Serologic markers alone do not necessarily signify liver disease, only that a particular viral "infection" is present. But remember that certain antibodies may be present as a result of passive transfer through blood transfusions or immunization with ISG or HBIG, or of vaccination with HB vaccine, so they don't always mean active infection.

Sometimes serial tests are needed to arrive at a definite diagnosis. A seroconversion or substantial increase in antibody titer points to a recent infection.

To make sense of a patient's hepatitis profile, it's necessary to know the significance of the individual markers.

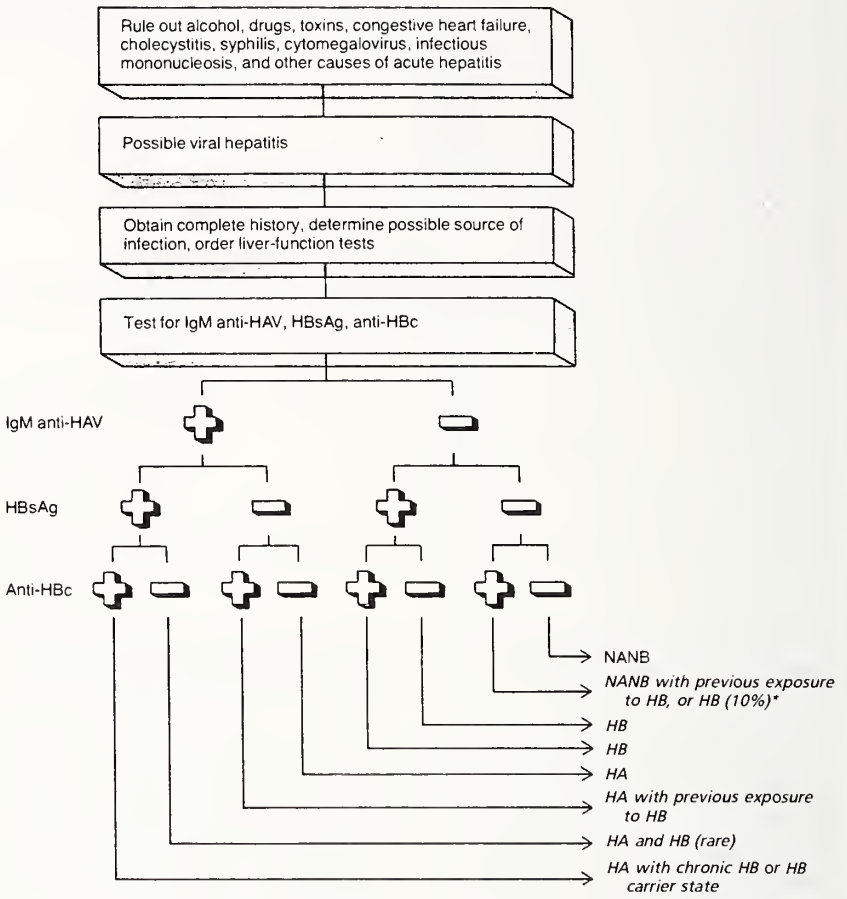
Anti-HAV: A patient whose serum contains IgM antibody to HAV has acute or recent HA. If the IgM anti-HAV test is negative but IgG anti-HAV is present, the patient either is in the recovery stage of HA or has had previous exposure to the virus and is now immune.

HBsAg: If serologic tests show HBsAg, the patient may be about to develop or already have acute HB. (However, only about 90% of those with acute HB have positive HBsAg tests; to diagnose HB in the remaining 10%, testing for other markers is necessary.) Asymptomatic patients with HBs antigenemia need close clinical follow-up with liver function tests and repeated serologic tests. Some of them (about 5% of those exposed to HBV) may be carriers. The carrier state may continue for several years or indefinitely.

HBsAg becomes undetectable when liver function returns to normal in about 80% of patients. If HBsAg persists for longer than 8-10 weeks, the patient is likely to develop chronic hepatitis and should be retested periodically for HBsAg, HBeAg, anti-HBe, and anti-HBs.

Intact HBV particles are required to produce infection, but only a small fraction of circulating HBsAg is associated with intact viral particles. As a result, some patients with a high HBsAg titer have low infectivity, while some with a very low HBsAg titer but large numbers of intact HBV particles are highly infectious. Patients with HBs antigenemia should be regarded as potentially infectious whether or not they are symptomatic.

FIGURE 3
Workup for Patients with Acute Hepatitis



*To distinguish between the two, test for anti-HBs and anti-HBe. If anti-HBs is positive, or both anti-HBs and anti-HBe are negative, the patient has had HBV infection in the past and now has NANB. If anti-HBe is positive and anti-HBs is negative, the patient has acute HB.

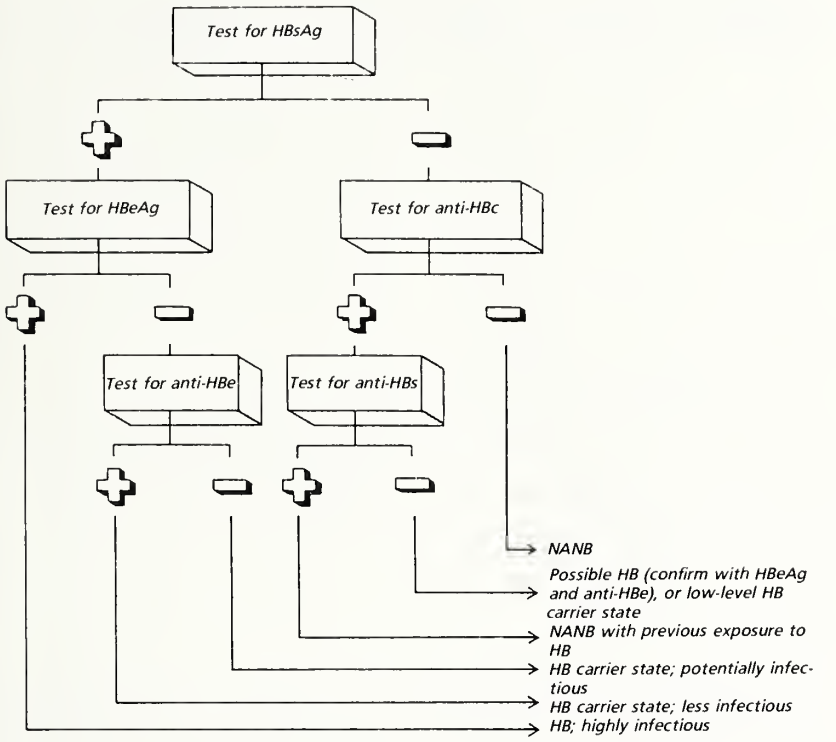
Anti-HBs: The presence of anti-HBs signals immunity to further HBV infection. Patients with this marker who have recently had clinical HB are in the late convalescent stage, on the way to complete recovery, and are no longer infectious (with the one exception discussed below). Others may have had prior exposure to HBV. The immunity conferred by active infection, clinical or subclinical, is probably lifelong. However, about 20% of people fail to develop anti-HBs after HBV infection.

The duration of effective prophylaxis after passive transfer of the antibody is variable but is probably at least three to four months. Anti-HBs has a half-life of 25 days and may be detectable six to eight months after administration of HBIG.

Rarely, HBsAg coexists with anti-HBs. This suggests that the patient has either acute fulminant hepatitis or chronic active hepatitis. Such patients are considered infectious. Those with acute fulminant hepatitis frequently have immune-complex diseases such as polyarteritis, glomerulonephritis, and polyarthritis; their prognosis is poor.

Anti-HBc: The antibody to core antigen does not confer immunity to HB. HBcAg may be present in hepatocytes at the same time anti-HBc appears in serum. A positive anti-HBc test usually means the patient has acute HB or is in the

FIGURE 4
Workup for Patients with Chronic Hepatitis



recovery phase. Patients recovering from HB whose only serologic marker is anti-HBc (core window) are potentially infectious. The anti-HBc is of the IgM type and is usually present in high titer. These patients need follow-up until anti-HBs appears, signaling complete recovery.

Anti-HBc as the sole marker may also indicate a low-level carrier state. HBsAg is present at an undetectable level, while IgG anti-HBc is present in high titer. A patient with this picture is also considered infectious.

Sometimes, long after exposure to HBV, the anti-HBs assay becomes negative while anti-HBc remains detectable. The anti-HBc is present in lower titer and is IgG. In theory, patients with this history are immune to HB and are not infectious. Because of the absence of anti-HBs, however, they are considered potentially infectious.

HBeAg: A positive HBeAg result means a patient has acute or chronic HB or is a carrier. HBeAg is present only in serum positive for HBsAg. The great majority of patients with acute HB experience HBe antigenemia. The presence of the antigen signifies active viral replication, so patients with it should be regarded as highly infectious. HBeAg correlates very well with the presence of intact viral particles and DNA polymerase activity.

Patients with persistent HBeAg have greater liver function abnormalities, and their illness has a longer duration. They are more infectious than patients whose HBe antigenemia is more transient, and if they are pregnant, they are more likely to pass the infection to the fetus.

Anti-HBe: Development of anti-HBe indicates resolution of HB. (About 50% of people with HBV infection do not develop detectable anti-HBe, however.) Those with anti-HBe are potentially infectious, although less so than those who have HBeAg but not anti-HBe. Their liver function is less abnormal, and they show less chronicity. Nevertheless, they should be followed up until the appearance of anti-HBs to verify complete recovery and immunity.

Anti-HBe usually appears shortly before the disappearance of HBeAg. Occasionally, however, seroconversion may not occur for weeks to months. The period when both HBeAg and anti-HBe are negative is called the "e window." Patients with this serologic picture should have anti-HBe and anti-HBs tests monthly. Anti-HBe usually disappears before anti-HBs or anti-HBc.

Prophylaxis

The decision to administer immune globulin (IG) or HBIG after exposure to hepatitis depends on the type of exposure, the infectivity of the suspected material, the immune status of the exposed person, and the type of hepatitis involved.

After exposure to HA, IG (0.02ml/kgIM) should be administered as soon as possible. If it is given within two weeks after exposure, it reduces the attack rate by 80-90%.

The person exposed to HB should be tested for HBsAg, anti-HBs, and anti-HBc. If any of these tests is positive, HBIG is not indicated. The presence of anti-HBs, of course, indicates immunity. Persons with HBsAg should be followed up to see if they develop acute HB. The suspected infectious material, if available, should also be tested for HBsAg, anti-HBs, and anti-HBc. If it is positive for anti-HBs, it is not infectious. If it is positive for either HBsAg or anti-HBc, the material is potentially infectious. One may want to further test it for HBeAg to assess the degree of infectivity.

HBIG offers passive immunization to persons exposed to HB. The dose is 0.05-0.07ml/kgIM, given as soon as possible and repeated in 30 days. If HBIG is not available, IG may be given on the same dosage schedule. HBIG that is administered within seven days after exposure can decrease the hepatitis attack rate by 40-70%.

Pregnant woman who are HBsAg-positive may transmit HB to

TABLE 3
Interpreting Hepatitis Profiles

IgG anti-HAV	IgM anti-HAV	HBsAg	Anti-HBc	Anti-HBs	HBeAg	Anti-HBe	Interpretation
−	−	−	−	−	−	−	1
+	+	−	−	−	−	−	2
+	−	−	−	−	−	−	3
−	−	+	−	−	+/−	−	4
−	−	+	+	−	+/−	−/+	5
−	−	−	+	−	−	−/+	6
−	−	−	+	+	−	−/+	7
−	−	−	−	+	−	−	8

Interpretations

1. *Possible NANB, other viral hepatitis, or liver toxin; no exposure to HAV or HBV, or very early incubation period of HA or HB.*
2. *Acute or recent HA.*
3. *Recovery phase of HA, previous exposure and current immunity to HA, or passive transfer of antibody.*
4. *Late incubation period or early acute HB.*
5. *Acute or chronic HB (HBeAg may be positive) or chronic carrier state (anti-HBe may be positive). In chronic carriers of HB, clinical hepatitis may be due not to HB but to NANB.*
6. *Acute HB, early recovery phase (core window), low-level carrier state (HBsAg present at undetectable level), or previous HBV infection.*
7. *Late recovery phase of HB or previous HB with recovery and immunity. Clinical acute hepatitis may be due to NANB or other agents or toxins.*
8. *Previous HBV infection long before, with recovery and immunity; passive transfer of antibody; or HB vaccination.*

their newborn infants. If the HBsAg-positive mother is HBeAg-positive, her infant will have a 90% chance of acquiring HB. It has been shown that 0.5ml. of HBIG given immediately after birth and at three and six months will prevent up to 75% of HB infections.

Currently there is no definite prophylaxis against NANB. IG has been proposed for the prevention of transfusion-associated NANB, and many studies have been published on the effectiveness or lack of effectiveness of this approach. The difficulty, of course, is in establishing efficacy when there is no means of identifying infected persons or those who are already immune.

The development of the HB vaccine has provided an effective means of preventing that disease. At present, vaccination is recommended only for people at particularly high risk of the infection: health-care workers, (especially those who handle blood) homosexual men, residents and staff of mental institutions, IV drug addicts, prostitutes, sexual contacts of persons with acute or chronic HB, hemodialysis patients, and prisoners. Those who are HBsAg carriers or have previously been infected do not need it, although it will do no harm.

Observation of more than three thousand people who participated in the double-blind, placebo-controlled trials of HB vaccine revealed that the only increased side effect in those who received HB vaccine was transient soreness at the site of inoculation. No serious side effects or illnesses which appeared to be causally related to the vaccine occurred among the 200,000 recipients. No known cases of HB or NANB hepatitis or acquired immune deficiency syndrome (AIDS) have been associated with the vaccine.

Data are not available on the safety of the vaccine for the developing fetus. The vaccine contains only non-infectious HBsAg particles. The risk to the fetus from the vaccine should be negligible. Pregnancy should not be considered a contraindication for women who are otherwise eligible to receive HB vaccine.

HB vaccine 0.5ml. may be given at birth or a week later to newborn infants of HBsAg-positive mothers, in addition to the HBIG. The HBIG provides immediate protection while the HB vaccine offers a long-term prophylaxis. The second and third doses of vaccine should be given one and six months after the first injection.

The decision to perform prevaccination screening is based largely on the cost-benefit ratio of screening, the prevalence of HBV markers and the annual attack rates in the target population. In general, if the prevalence of prior HBV infection is greater than 20% and the cost of screening is less than $30 per person, prescreening is recommended. Testing for anti-HBs will identify all previously infected persons, except for carriers. The anti-HBc test will identify all those previously infected, carriers and non-carriers. For groups with expected carrier rates less than 2%, such as health-care workers, the tests will yield similar results. For groups with higher carrier rates, the anti-HBc test may be preferred to avoid unnecessary carrier vaccination. Screening not only identifies candidates for HB vaccination. It also provides clues to high-risk areas by demonstrating high rates of seroconversion.

Because the vaccine is a purified suspension of inactivated HBsAg, the only antibody it provokes is anti-HBs. About 95% of healthy persons have an antibody response after the three doses. Antibody passively acquired through ISG or HBIG injection will not interfere with active immunization. Revacci-

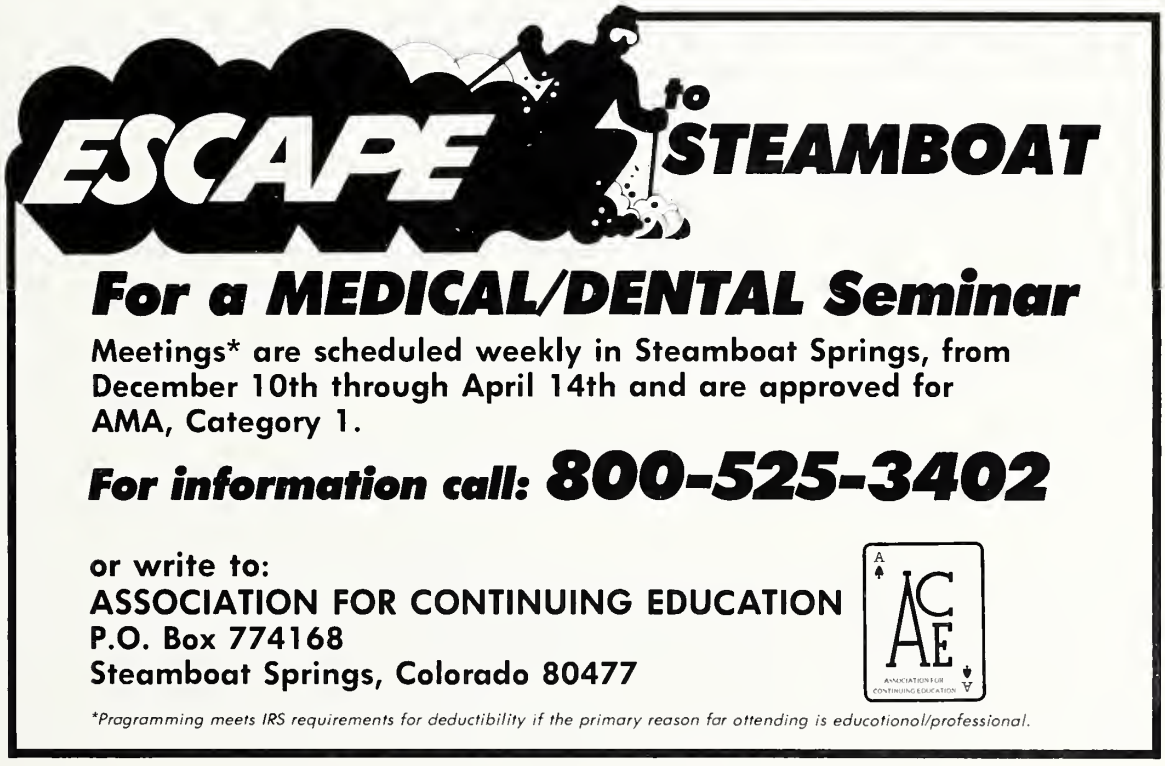
nation has produced antibody in only one-third of previous nonresponders. There seems little need to test for immunity following vaccination except in dialysis patients, whose subsequent management depends on their immune status. The vaccine has a reported efficacy rate of 80-95%.

In view of the demonstrated safety and efficacy of the vaccine, its benefits for persons who are at high risk of acquiring HB infection far exceed the theoretical long-term risks

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Report of a Hepatitis Immunization Program

By Fred Z. White, M.D.,/Chillicothe

The Methodist Medical Center of Illinois recently completed a hepatitis B immunization program for its employees. This is the first such completed program in Illinois. The process through which this program has been achieved and the experience of this 550 bed institution in carrying out the immunization program should be of value to other hospitals and medical centers in the state who are contemplating such an immunization program.

When the availability of hepatitis B vaccine to the general population became known, our active medical staff established an ad hoc committee to discuss an immunization program. This committee was composed of the infectious diseases committee chairman, a pathologist, the employee health physician, the president of the active medical staff, and the chief of gastroenterology. This ad hoc committee investigated the value of and risks from the vaccine in view of the potential risks of hepatitis B to the employees of the medical center. From their deliberations came the recommendation that an immunization program should be instituted and targeted to high risk employees.

A hospital ad hoc committee was then formed, again including the appropriate members of the active medical staff, but also including representatives of the administration—the vice president for nursing and others.

Having made the decision that an immunization program would be in the best interest of the institution, decisions were then made as to the high risk areas and individuals involved in the medical center activities.

The areas identified to be included in the program were surgery, cardiovascular surgery, the intensive care units, employees in the pathology department, residents in training in the medical center, emergency room and oncology personnel. Other specific individuals who were frequently involved in handling blood products were later identified and included in the program.

At this point a recommendation was made to the hospital administration to embark on the immunization program with specific recommendations as to individuals to be vaccinated.

More than 500 individuals were identified by this means. This project represented a significant expenditure to the medical center but, recognizing the humanistic value of protecting employees and recognizing the cost that is involved with every potential hepatitis B exposure, the hospital administration authorized the program.

Specific guidelines were then developed. Although it was not mandatory that employees of the high risk areas receive the vaccine, it was strongly recommended that such employees be immunized. Employees in the high risk areas were offered the vaccine at no cost. Informational meetings were held with department heads and clinical coordinators. An immunization schedule was developed and the program was begun.

This immunization consists of three doses, a second dose given at one month and the final dose at six months from the initial dose. This initial immunization program was targeted to the employees presently working in the identified high risk areas. In an ongoing effort to protect employees, those transferring to or newly hired for high risk areas were also offered the immunization. This portion of the total protection effort will continue. However, the data presented speaks only to the initial cohorts of employees.

Employees not working in high

risk areas were offered the vaccine at cost through their private physicians.

The Immunization Experience

To assure complete employee records, employees who were offered the vaccine in the high risk areas but refused it were asked to sign a refusal waiver. It was agreed that employees who elected to waive the vaccine but who later decided to receive the vaccine would be offered the vaccine after all other high risk employees had been accommodated.

A total 594 employees in high risk areas were identified and offered the initial vaccine. Of these, 326 were from nursing service, 133 were from the laboratory, and 135 were from other units in the medical center.

Of this number, 421 (71%) availed themselves of the first dose. The second dose was given a month later and 411 immunizations were offered then. This represented a 2% attrition (due entirely to termination of employment).

The third dose, given six months from the first dose, was given to 348 employees. Twenty-six of the original 421 had terminated employment and were not available to receive the final immunization. This represents an 83% gross completion rate for the immunization program. If one removes the individuals who have terminated employment from these statistics (leaving 395 available to be immunized) we then have an 88% net completion rate. Many of those who have not received the third dose have moved to other areas and all will be notified that the third dose is lacking and that they should seek to get this at their present location. The gross attrition rate for the program, then, the total three dose immunization, was 17% while the net attrition rate was only 12%, which we think is exceedingly low. We consider the program to have been quite successful.

Comment

The success of a program of this sort depends on the support of the medical staff and the administration of the institution. Additionally, it requires the support of the department heads and chairs within the institution. It was noted that there was a difference in the percent of participation within the units so that the enthusiastic support of unit chairmen is essential to a complete immunization program.

The 98 percent completion of two doses is significant since the titer achieved after the second dose is exceedingly good. In the instance of one employee who did receive a significant exposure 3½ months after the second dose, his HBsAg was found to be reactive.

Adverse effects were noted in only two patients. One individual noted that after each of the three vaccine injections she ran a low grade temperature and noted generalized myalgia. This on all three occasions was noted 10 days after the vaccine and lasted for 36 to 48 hours. A second individual complained of generalized adenopathy following the second injection and elected not to receive the third injection. No other adverse effects were reported or noted.

Conclusion

Based on the experience of this program, the vaccination would appear to have minimal side effects; and an immunization program mounted at a hospital or medical center can be achieved with very good compliance by the employees who are at risk.

Correcting for the 26 individuals who terminated employment at the medical center during the six month period of time, this would yield an immunizable pool for the third dose of 395, or a net immunization rate of 94% with a net attrition rate of 6%. ◀

Fred Z. White, M.D., M.A. (Ed.), is a diplomate of the American Board of Family Practice and a fellow of the American Academy of Family Physicians. An associate professor at the University of Illinois College of Medicine in Peoria, Dr. White is also an adjunct professor of education at Bradley University. He is a member of the board of trustees of the Methodist Medical Center of Illinois, Peoria, where he serves as associate director for the Family Practice Residency Program and is a former president of the active medical and dental staff.

An ISMS past president, (1981-82) Dr. White is presently chairman of the board of governors for the Illinois State Medical Inter-Insurance Exchange. A former ISMS trustee, he is a past president of the Peoria Medical Society, Peoria Tazewell Heart Association, Illinois Heart Association, Peoria Board for Medical Education and Midstate Foundation for Medical Care.

Hepatitis B Vaccine Recommended

Persons at high risk of contracting hepatitis B should be vaccinated, according to a recent American College of Physicians news release and a statement ACP published in the January issue of the *Annuals of Internal Medicine.*

ACP's Clinical Efficacy Assessment Project (CEAP) director, J. Sanford Schwartz, M.D., stated that nearly 100% of patients who receive the proper dose sequence and who develop the usual antibody responses are protected. In addition, no serious immediate or long-term reactions to the vaccine, or cases of vaccine-transmitted hepatitis B disease, are known.

Effective Communication

By Roger P. Smith, M.D./Urbana

We have all faced the disappointment of finding that a topic which looked so interesting in the meeting program is so badly presented that even the speakers' own colleagues are tempted to leave the meeting hall. Less often, we are treated to a presentation on a subject in which we had no interest at all, but is so well presented that we are caught up and infused with the speaker's enthusiasm and knowledge. What separates these two situations is not innate ability, but simple planning and a few guidelines easily followed by anyone worthy of taking the podium.

The methods and techniques that work well for a written paper are not the same as those for oral presentations. The paper submitted to the program committee that won your place on the program is not what you should stand up and read. Your presentation should be based on this paper and should carry the same information, but there the similarity ends. In effect, if your presentation is going to be worth your introduction, you will need to completely rewrite your paper with oral delivery in mind. The process of re-thinking and developing your topic can be divided into three categories; planning, preparation and presentation. Each of these elements can make or break your chance for success, and none can be ignored.

Planning

Planning an oral presentation will be the most time consuming part of the preparation process. If you are working from a paper designed for publication, much of the basic planning of content and points of interest will have already been done. Still, the speaker must carefully decide what points are to be made. The better these points are defined and characterized, the more likely your success. Points that can be made in an oral presentation are far fewer and less than those in a published paper. In determining priorities, be sure to consider the needs and background of your intended audience. The same material must be presented in a much different way to a group of experts than to hospital volunteers.

Once you know what you need to achieve with your presentation, it is wise to make an outline of the points to be made in the order you wish to make them. This will establish the "flow" of the ideas. It is this sequence that leads the audience through the information. If this flow is poorly conceived or choppy, the audience will be lost in the process of moving from one point to the next. The presentation should be viewed as a complete unit, logically constructed of smaller ideas whose relationships are clear and appropriate. This will also ensure that there will be a consistent overall tone and treatment. The construction of this sequence of points may be aided by the use of a "story board" or a set of four by six inch file cards. Either method makes it easy to visualize the path as planned and allows revisions as needed.

Visual Aids

When satisfied with the sequence to be used, you may next plan your slides. Slides serve to hold the attention of the audience, to clarify points, to provide a common starting point, and to overcome space and time limitations. Design will determine whether they help or hinder the transfer of information. Each slide should achieve a simple message, visual variety without inconsistency and readability. Each should be concise, simple and purposeful. Ideally, each slide should stand by itself. When this is not possible, one or two preceding or following slides may be needed.

Never make three points with one slide when you can make three points with three slides. The slides will be easier to understand and will provide a faster and better paced

presentation. Nothing loses an audience faster than an unreadable slide left on the screen for ten minutes. If you must come back to a point later on in a presentation, use duplicate slides. This saves backing up and going forward again, or having the projectionist search (usually in vain) for the slide you need.

When complex material must be presented, attempt to break it up into smaller bites that can be presented individually. When the information is numerical, try to use graphs or pie-charts rather than tables. Graphs convey information and relationships much more quickly and visually. If graphs are used, use bold lines or colors and show only essential data. When the complex information is primarily made up of words or lists, consider using a "progressive disclosure". This is a series of slides that progressively add a point to those presented by previous slides. This is often seen as a slide sequence that adds each element in the list as it is being discussed. When each item is added, all of the previous ones are still visible for continuity, but the audience's attention is focused on the point at hand. This may also be done by highlighting or emphasizing each element of the complete listing as it is presented. Either way, the point you wish to make is more obvious but still related to its larger context.

With the sequence of ideas and content of your slides determined, it is wise to make rough sketches of each of your slides. If you use 4×6″ file cards for your "story board", their 2:3 ratio is ideal for test running what a slide will look like. With these cards you can lay out the format and determine the "look" of each slide before it is produced. You may even decide that an idea for a slide is too complex or impractical to produce. This is also the stage to edit the words each slide will use. Fifteen words or less per slide is a wise limit. (An effective billboard often has five or less words!) It is also wise to try to use only horizontal format slides. This provides consistency in your talk, gives a larger effective working area, and avoids problems with the top or bottom of the slide running over a short screen to the wall behind it.

Preparation

Art work, graphics and text slides are easy to produce with simple materials and little skill. Even if you send your slides out to be produced, some understanding of the process will ease planning and enhance results.

Even a non-artist can easily produce art for slides. The art is there only to help convey a point, not to steal the show or stand alone in a gallery. Simple illustrations, even stick figures, will often do very well. For the really timid, commercial slide suppliers often have stock slide art for purchase. Collections of non-copyrighted drawings of a general type are also available from many suppliers. Try to keep illustrations simple, visually interesting and colorful. Do not overwork illustrations. Let the number and type vary with the content and mood or the topic at hand.

Production of graphs and line drawings must almost always be overseen by the presenter, even if the finished graph will be photographed by someone else. Graphs should also be simple, concise, and, above all, readable. To achieve this goal, lay out your graph on a work board or sheet of paper 6×9″ (153mm × 229mm). This gives the 2:3 ratio of the finished slide, is a convenient size to work with, and is easy to photograph. When drawing a graph remember to make curves and data more prominent than the axes. A good line size for a curve on a 6×9″ graph is 0.073 inches (1.9mm). A graph of this type should have lettering at least 0.047 inches (1.2mm) in line thickness, and the axes should be drawn with 0.028 inch (0.7mm) lines. Drawing pens are readily available in appropriate sizes or thin tapes may easily be used. If colors are used, they should be in high saturation with good contrast to each other and the background. Consider thickening the lines to increase visibility even more when colors are used. A background color other than white often helps to reduce glare and make lines more visible, but don't make it the star of the show.

The most common type of slide you will use is also the easiest to do badly. This is the text or title slide. Slides which contain only text can too often be crowded, illegible, and boring. These slides are also the simplest to produce correctly with only a little forethought and a few common sense rules.

Text and Title Slides

It's fastest to produce text slides with a typewriter. To do this, first set up a template sized 3×4½″ (76mm × 115mm) to act as a typing guide. This will allow a maximum of nine double space lines. Each line may contain 54 elite or 45 pica characters, although the number is best kept well under this. When a slide of this type is projected to a size of 5 feet (1.5m), elite type will be legible at 40 feet (12.2m) and pica may be read at 60 feet (18.3m). The use of upper case letters will only slightly extend these distances. To further reduce the chance of overcrowding your text, you can use a 2×3″ typing template to ensure readability.

A good rule of thumb is that if a slide may be read without magnification it will probably be readable for the audience. A more universal formula is the "rule of eight": To determine the maximum viewing distance for a slide, multiply the projected lettering's screen size in inches by eight to get the distance in feet. This means that a twelve inch projected letter will be readable 96 feet from the screen.

If you use a typewriter for lettering be sure to use one with clean type and a carbon film ribbon. Carbon film ribbons provide a clean, dark type face that is generally better than that obtained with cloth. If a cloth ribbon must be used, try placing a sheet of carbon paper face up on the back of the paper you are typing on. This additional carbon on the back of the paper will sometimes help to darken and define the letters on the front. While most bond paper will work, the ideal paper is a clay coated photoreproduction paper. This has a smooth, non-glossy surface which gives excellent clarity to the letters. If proportional spacing is available on your typewriter, the lettering will

have a more pleasing visual effect without losing readability.

If you want to change type style, size or boldness, or need to letter on a surface which does not fit into a typewriter, an alternate lettering method must be used. Many possibilities exist. The most common are pressure sensitive dry transfer lettering. Available in sheets, these letters may be rubbed into place to create many different effects. Moveable ceramic letters, magnetic plastic letters, chalk, or colored pencils may all be used in the right setting. Whatever is used, the same rules of content apply as for typed copy discussed earlier. Because vertical spacing is not automatic, as on a typewriter, you should allow at least the height of an upper case letter between the lines. The width of an upper case letter can be a good guide to the separation between words as well.

Once the layout, lettering, art, or graph has been produced it is ready to be photographed into a slide. This can often be done by a professional photographer, hospital photography department, or very easily on your own. To do your own slides, you will need only a camera, artwork to be photographed and a source of light. If you are going to use reflected light, a minimum of two lights should be used. These are placed at an angle of 45 degrees to the camera-subject axis and approximately equally spaced from the subject. This placement may be checked by placing a pencil on top of the copy to be photographed. The shadows made should be equal in size and density if your lighting is correct.

Probably the easiest film to use is the everyday color slide film you normally use. Your familiarity with its characteristics will do much to make you comfortable and your results predictable. Using filters to add or subtract color, even black and white art work can be made colorful and interesting. Don't forget that the film you use outdoors may require color corrections or different lights to get normal results indoors. High contrast copy films may be used for text or graphic slides. These slides are only black and white (no gray) and are generally produced as a negative (white letters on a black background). While negative slides have good readability and contrast, they can be harsh and boring. To avoid this the clear (white) areas may be tinted with felt-tip pens or food coloring to produce colors on a black background. If this technique is used it is best to tint both sides of the slide to get better color saturation and uniformity. Very creative things may be done with special films, filters, and processing, but excellent slides may be made very simply without expert knowledge.

Presentation

The presentation of a paper is often the part most feared by inexperienced speakers, but it can be the easiest part if the planning and production process has been carefully done. Presentation is more than just speaking before the audience. Here again, some simple things can make the difference between applause and yawns.

First, before you even leave for the meeting site, several things must be done. You should plan on practicing your presentation several times, with your slides. This gives you a chance to make last minute edits, check the pace and "flow," be sure the slides project well, and allow you to become familiar with their sequence. At this point you should know what you will say with each slide and may make notes to use if that makes you more comfortable. These notes should only be reminders and should not be read to the audience. When you are familiar enough with your slide sequence, the slides themselves should be enough of a reminder. Don't forget: you can't rehearse too much.

Be certain that the program organizers know your equipment needs. If you need special equipment, you will want to give adequate time for the equipment to be located prior to the meeting. It is always wise to request that slides be controllable from the speakers podium. This saves interruptions and allows you to control the pace. When this is not possible, arrange a light signal with the projectionist using a simple pen-light. (Don't forget to carry one with you, along with a collapsable pointer.) When possible, request information about the size and shape of the meeting room, screen size and placement, and the ability to darken the room. All of these factors will affect your presentation, and possibly even the production of your slides.

When you travel, always carry your slides with you, not in your luggage. It is one thing to lose your shirts, and quite another to lose your slides. Consider carrying your slides in the appropriate type of projector slide tray or carrier. This insures that your slides will be ready to show, right side up, and in proper order when you arrive. Placing a blank (black) slide at the end of your slides will prevent your lecture from ending with a flash.

On or before the day of your presentation, try to check things out at the meeting room. Is the equipment you need present and working? Is the screen large enough and in the right location? Can the room be darkened enough? Where are the light switches? Many of these things you will have no control over or will already have been done. If you are the one responsible for doing them, they are simple things that will make your presentation go smoothly. If you have a choice of screens, you may use the rule of eight, mentioned earlier, to determine the ideal screen size for slide visibility. Also remember that no one should be seated further to the side than a 30 degree angle from the projector-screen axis. Beyond this angle, little light is reflected and the slide becomes useless.

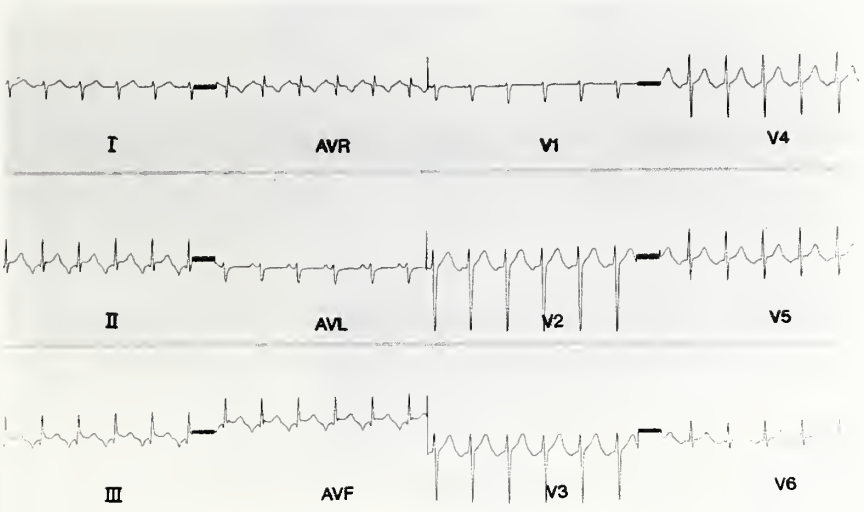
Summary

Your actual presentation can be made more relaxed and enjoyable with a few simple tricks. Never read your paper to the audience. Even though we speak of "papers read before the meeting," don't do it. Read your paper BEFORE the meeting and then paraphrase your points in your own words when speaking to the group. And don't read your slides to the audience. Let them do it for themselves. You spent a lot of time making the slides so they could do just that. The slides are there to reinforce your presen-

(Continued on page 133)

EKG OF THE MONTH

Contributing Editors John F. Moran, M.S., M.D., David J. Hale, M.D., John R. Tobin, M.S., M.D. Rolf M. Gunnar, M.S., M.D., and Patrick J. Scanlon, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a 37 year old man who had bouts of palpitations off and on for eight years. He was given a trial of digoxin at one time but this apparently did not control the palpitations and was discontinued. Later he was started on propranolol. The patient stopped taking the propranolol because of intolerable fatigue. No longer on any medication, he was brought to the emergency service following a seizure. There was a vague history of concussion at age 13 and an abnormal electroencephalogram. His wife said that his arms and legs shook for one or two minutes and then his eyes rolled back in his head. The patient is now alert and denies tongue biting or bowel and bladder incontinence. His physical exam is significant for a pulse rate of 145 beats per minute. The blood pressure was 110/70 and the remainder of the physical and neurological exam was normal. A chest X-ray and complete blood count are normal. This twelve lead ECG was taken.

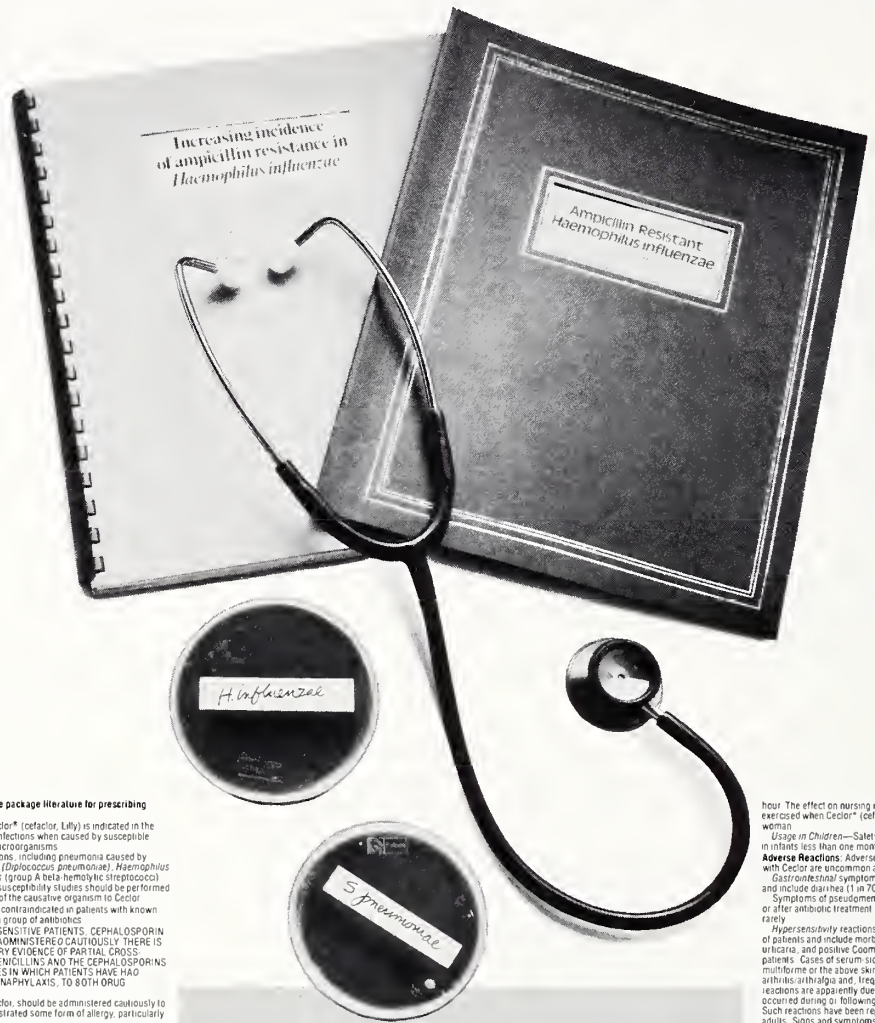
Questions:

1. The twelve lead ECG shows:
 a. A normal ECG except for sinus tachycardia.
 b. Atrial flutter with 2:1 atrioventricular block.
 c. An atrial tachycardia.
 d. Coronary sinus rhythm.
 e. All of the above.

2. Appropriate management of this patient could include:
 a. Repeat electroencephalogram.
 b. Neurology consultation.
 c. ECG telemetry to monitor for arrhythmias.
 d. Intravenous digoxin.
 e. Intravenous verapamil.

(Continued on page 129)

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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ISMS Focuses on Reimbursement Issues

The medical profession's time-honored commitment to "usual, customary or reasonable" (UCR) as the reimbursement mechanism for physician services is coming under scrutiny as cost containment pressures build. The issue of UCR vs. other payment mechanisms is expected to be a subject of debate at the annual meeting of the Illinois State Medical Society (ISMS) House of Delegates, April 6-8, at the Chicago Downtown Marriott Hotel. ISMS action is anticipated in the wake of the American Medical Association (AMA) House of Delegates request for comments from state medical societies and other groups within organized medicine. At this writing, the Board of Trustees had approved a resolution drafted by the ISMS Council on Economics for submission to the House of Delegates.

At its December meeting, the AMA House voted to "recognize the validity of a pluralistic approach to third party reimbursement methodology." However, it refused to approve a recommendation from the Association's Council on Medical Service which would have had the AMA withdraw its advocacy of UCR as the "preferential" method of determining reimbursement levels. Corresponding ISMS policy now provides that the Society "endorses the AMA policy on physician reimbursement, which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule."

At issue is the AMA Council's original recommendation for support of an indemnity-based system under which third parties would offer set schedules of benefits. Since issuance of the report, proponents of the change in AMA policy have been quick to point out that they are not in favor of abandoning UCR, *but simply allowing acceptance by the AMA of other payment mechanisms.* Opposition to the Council recommendation stems from long-standing objections to use of fee schedules to set physician reimbursement.

In one of two reports to date on the subject, the AMA Council said that the change to an indemnity system could bring improved patient-physician interaction since neither physicians nor patients would have false expectations that the amount of third party payment necessarily represented payment in full. Proponents of indemnity maintain that third party payors' manipulation of physician UCR reimbursement profiles often leads to conflicts when reimbursement falls short of the physician's entire bill.

Advantages to patients cited by the Council include ensuring continued free choice of physicians rather than restriction to "participating providers" and improved understanding of insurance coverage. For insurers, an indemnity system would help simplify premium rate calculation and reduce administrative costs, according to the Council.

AMA Analysis to Continue

The resolution passed by the AMA House of Delegates in December recognized indemnity reimbursement as having positive aspects which "merit further in depth study." The House directed the AMA to continue its analysis and submit additional comments along with those received from oth-

er organized medicine groups to the AMA Council on Medical Service. The Council was to present further recommendations at the AMA's Annual Meeting in June.

The AMA House also voted to reaffirm AMA policy supporting: (1) freedom for physicians to choose their method of payment for their services and to establish fair and equitable fees; (2) freedom for patients to select their source of care; and (3) neutral public policy and fair market competition among alternative health care delivery and financing systems. Physicians were urged by the House to volunteer fee information to patients and to discuss fees in advance of services whenever feasible.

Another important part of the AMA action was a recommendation that physicians expand the practice of accepting third party reimbursement as payment in full in cases of patient financial hardship.

Balance Billing Supported

Nonetheless, in reaffirming that the primary relationship is that between the physician and the patient, the AMA House acted to "support the right of the physician to balance bill a patient for any care given, regardless of method of payment where permissible by law or contractual agreement."

The issue of balance billing has become a key part of the debate over any change from UCR methodology. The AMA Council has cited increasing pressure on physicians to accept payor-determined reasonable charges as payment in full. Such pressure has been exerted through:

—Insurance plan or company contracts which allow payment only when services are provided by "participating" physicians;

—Patient-physician conflict which results from patient misunderstandings of "explanation of benefit" letters;

—Increasing consideration of mandatory assignment or fee schedules under Medicare; and

—Multiplying numbers of "hold harmless" communications from insurers advising their patients not to pay physicians the portion of bills that exceeds their allowances and offering to defend the patient in any collection action brought by the physician.

Insurer Interference Opposed

The issue of hold harmless communications has been examined in depth by ISMS legal counsel. Although not yet widespread, such incidents have raised serious concern on the part of the Society. ISMS strongly believes insurance companies that advise patients not to pay physician bills are acting illegally and unprofessionally.

It is the Society's position that insurance companies enter into contracts to pay their insureds certain benefits and that those contracts do not authorize—much less require—insurance companies to induce patients to breach their contracts with physicians. Once an insurance company satisfies *its* contractual obligation to its insured, it has no legitimate interest or right to involve itself in the physician-patient contractual relationship, according to ISMS.

To help avoid such problems, ISMS is advising physicians that they should, whenever practical and appropriate, inform their patients clearly that it is the patient who is primarily responsible for full payment of the physician's fee, without regard to the existence or amount of any insurance coverage. ISMS suggests that a written record be kept documenting that the patient has been so informed and has agreed.

The Society's legal counsel suggests that one measure to accomplish this would be to include lan-

UCR vs. Indemnity

A grasp of the terminology used in the emerging debate is crucial to an understanding of the ramifications of changes in AMA and ISMS policy with respect to physician reimbursement mechanisms.

UCR originally was a methodology whereby the physician determined his or her own fee. Proponents of the change from UCR say serious problems have resulted from third party payors—including government—"bastardizing" the concept of UCR to suit their own purposes.

Generally, the "usual" component of UCR has been understood to mean that charge which is usual for the individual physician. The "customary" component was comprised of charges for the same procedure by physicians with similar training in the same region. It is differing viewpoints of the "reasonable" component of UCR that have given rise to the current debate.

As originally intended, UCR was to mean usual, customary *or* reasonable, with "reasonable" invoked to permit reimbursement of a physician's charges beyond those which were usual and customary if peer review determined that the extra charges were warranted. As medical care costs have risen, third parties—especially government payors under Medicare and Medicaid—have taken UCR to mean "usual, customary, *and* reasonable," with "reasonable" defined in such a way as to limit physician reimbursement.

In focusing on an indemnity system, the AMA Council on Medical Service envisions payments under an indemnity system to be made from a schedule of allowances. However, the Council maintains that an indemnity schedule should *not* represent a maximum fee schedule. Physicians still would be able to charge patients what they determined to be fair and equitable fees under the system advocated by the Council.

guage similar to the following on an information form, consent form, or other material signed by the patient:

> Patient agrees to pay in full the charges of Dr. _____ for all treatment and procedures performed, regardless of whether such charges are approved by patient's insurance company and regardless of whether patient's insurance company approves and/or pays less than the charges of Dr. _____ .

In addition, ISMS advises that, wherever practical, patients should be informed in advance of the specific fee to be charged or the method that will be used to calculate the fee. Language such as the following also may be used in an appropriate form:

> The charges of Dr. _____ are set forth in the professional fee schedule which is available for inspection. All prices are subject to adjustment without prior notice due to, among other things, the complexity of the treatment or procedures performed.

If physicians' problems with patients over insurance reimbursement persist, the Society suggests that they seek advice from their legal counsel. ◀

ISMS Offers Pamphlet on Women's Athletics

The Illinois State Medical Society (ISMS) is making available to physicians a pamphlet debunking many myths regarding athletic participation by women. The pamphlet, "The Female Athlete: A Look At The Facts," is intended for distribution to patients and was developed by the ISMS Sports Medicine Committee in conjunction with Marianne Porter, a certified athletic trainer.

Available at a cost of $10 per 50 copies for ISMS members and $20 for non-members, quantities of the pamphlet may be ordered from the ISMS Division of Medical Services, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

The pamphlet informs readers that advice to women concerning athletics which was formerly regarded as "common sense" sometimes "makes no sense at all in light of sports medicine research." It advises that some misunderstanding regarding female physiology persists which deserves analysis. Information presented in the pamphlet addresses effects of athletics on the uterus, breasts, menstruation, and pregnancy as well as a discussion of female physiology, risk of injury and need for equipment. Among points raised in the pamphlet are:

—No evidence is available to support former advice for women to avoid strenuous running and jumping which may have been believed to cause stretching of uterine ligaments which could have allowed the uterus to "slip."

—The common fear that repeated blows to breast tissue cause cancer is likewise not supported by scientific evidence.

—Aside from those experiencing incapacitating discomfort, menstruating women need not avoid strenuous activity.

—Most pregnant women can continue to engage in athletic activities. Women who continue to be active during pregnancy can have healthy infants, and also may feel better throughout the pregnancy and have easier and safer deliveries.

The pamphlet states that while there are sex-related factors such as height and lean body weight which affect athletic performance, there is no evidence that vigorous activity is psychologically unsafe or unhealthy for either sex. Non-contact and endurance activities pose no physical threats to participants, and some women can surpass some men in such events. For contact sports, participants—male of female—should be matched with respect to size and weight since those individuals with greater mass are capable of generating more momentum which can inflict serious injury on an overmatched opponent. ◀

Primary Election Day Tuesday, March 20, 1984

Illinois voters will go to the polls on Primary Election Day, March 20, 1984, to nominate Democratic and Republican Party candidates for the Fall General Election. Voters will cast ballots in their respective party elections for the 20 State Senate seats up this year, all of the 118 seats in the Illinois House of Representatives, the 22 U.S. House of Representatives seats from Illinois and one U.S. Senate seat. On the local level, various county-wide candidates such as state's attorney and circuit clerks will be determined.

Both parties will also conduct delegate and alternate delegate elections for party conventions to be held in the summer. While presidential candidates will also appear on March ballots in a "beauty contest," the results will not actually determine who the nominees will be. Delegates and alternates actually select their parties' candidates.

The ISMS Public Affairs Committee urges all physicians, spouses and family members to participate in this most important civic right. This participation need not be limited to simply casting a ballot on election day, but can be extended to actively supporting the candidate or candidates of your choice throughout the campaign. This support can take many forms, such as serving on the campaign or finance committee, hosting a coffee or arranging meetings with local civic groups. Persons interested in becoming actively involved in volunteer campaign activities should contact the candidate or call the ISMS Chicago office for assistance.

Listed below are the Democratic and Republican candidates who have filed petitions to appear on the ballot for the offices of U.S. Senate, U.S. House of Representatives, Illinois Senate and Illinois House of Representatives. *Incumbents are indicated by an asterisk.*

For U.S. Senator

Democratic

Roland W. Burris, Chicago
Philip J. Rock, Oak Park
Gerald M. Rose, Chicago
Alex Seith, Hinsdale
Paul Simon, Makanda

Republican

Richard J. Castic, Glen Ellyn
Tom Corcoran, Ottawa
V.A. Kelley, Beecher
Charles H. Percy, Wilmette*
John E. Roche, Palos Park

For Representative in Congress

Congressional District	Democratic	Republican
1	Charles A. Hayes, Chicago* Sheila Jones, Chicago	
2	Robert Shaw, Chicago James C. Taylor, Chicago Gus Savage, Chicago* Glenn V. Dawson, Chicago Leon Davis, Chicago Emil Jones, Jr., Chicago	Dale F. Harman, Chicago
3	Martin A. Russo, South Holland*	Casimir G. Oksas, Chicago Arthur J. Jones,, Chicago Richard D. Murphy, Chicago
4	Gerald E. "Laser" Berg, Chicago Dennis E. Marlow, Calumet City	George M. O'Brien, Joliet*
5	William O. Lipinski, Chicago* Suzanne Rose, Chicago	John M. Paczkowski, Chicago
6	Robert H. Renshaw, Lombard Warren L. Jewel, Jr., Elmhurst	Henry J. Hyde, Bensenville*
7	E. Denardo Monroe, Chicago Cardiss Collins, Chicago* Danny K. Davis, Chicago Edward Florence, Chicago Joseph Nathaniel Gomez, Chicago	James L. Bevel, Chicago Larry Saska, Chicago
8	Dan Rostenkowski, Chicago* Gerald Pechenuk, Chicago	Spiro F. Georgeson, Chicago
9	Sidney R. Yates, Chicago* James A. Wright, Chicago Michael C. Markovitz, Chicago	Herbert Sohn, Skokie
10	Ruth C. Braver, Highland Park Mark D. Adams, Arlington Heights	John E. Porter, Winnetka*
11	Frank Annunzio, Chicago* Anthony K. Wikrent, Norridge	Charles J. Theusch, Chicago Daniel Schmitt, Chicago William J. Grutzmacher, Chicago
12	Edward J. La Flamme, Round Lk Bch.	Philip M. Crane, Mt. Prospect*
13	Robert J. "Bob" Bily, Lemont Michael J. Donohue, Naperville Carl N. Schoeppel, Chicago	Donna N. Sumanas, La Grange William M. Snyder, Jr., Clarendon Hills Terrence Michael Jordan, Riverside George "Ray" Hudson, Downers Grove Mark Q. Rhoads, Western Springs Diana Nelson, Western Springs Stanley S. Borys, Naperville Kyle Kenley Kopitke, Naperville Harris W. Fawell, Naperville
14	Greg Sparrow, DeKalb Eugene Mabeus, Batavia Dan McGrath, Ottawa	Richard L. Verbic, Elgin Tom Johnson, West Chicago John E. Grotberg, St. Charles John A. "Jack" Cunningham, Aurora C. Carl Lodico, Elgin

Congressional District	Democratic	Republican
15	John M. Hoffmann, Bloomington	Edward R. Madigan, Lincoln*
16	Carl R. "Skip" Schwerdtfeger, Elizabeth	Lynn Martin, Rockford* Kenneth F. Bohnsack, Freeport
17	Lane Evans, Rock Island*	Jack Michalski, Rock Island Kenneth G. McMillan, Bushnell Dan Lee, Rock Island
18	Gerald A. Bradley, Bloomington William D. Fogal, Pekin Henry G. Jackson, Jr., Murrayville	Robert H. Michel, Peoria*
19	Eric Jakobsson, Urbana John Gwinn, Champaign Terry L. Bruce, Olney Tom Lindley, Danville	Daniel B. Crane, Danville* Max E. Coffey, Charleston
20	Louis K. Widmar, Carlinville Richard J. Durbin, Springfield*	Richard G. Austin, Springfield
21	Melvin Price, East St. Louis* Floyd E. Fessler, Jr., Bethalto Sandra Climaco, Belleville	George (Ted) Farmer, Belleville Robert H. (Bob) Gaffner, Greenville Maurice Horton, East St. Louis Charles S. Russell, Belleville
22	Kenneth J. Gray, West Frankfort Ken Buzbee, Makanda	Randy Patchett, Marion

For State Senator

LEGISLATIVE DISTRICT		
1	Howard W. Carroll, Chicago*	Joseph R. Hedrick, Morton Grove
4	Dawn Clark Netsch, Chicago*	
7	Richard V. Valentino, Chicago Robert J. Egan, Chicago* Robert P. Reske, Chicago	Walter W. Dudycz, Chicago
10	Arthur J. McBride, Chicago John A. D'Arco, Jr., Chicago* Jerome J. Green, Chicago George S. Bynum, Chicago	
13	Richard H. Newhouse, Jr., Chicago*	
16	William Parker, Chicago Charles Chew, Chicago* John W. Moore, Chicago	
19	Bob Kaup, Orland Park	William F. Mahar, Homewood*
22	Darlene A. Perina, Berwyn	Judith Baar Topinka, Riverside
25		Doris C. Karpiel, Roselle

Legislative District	Democratic	Republican
28	Sam L. Amirante, Park Ridge	Bob Kustra, Glenview* Dotty Inga Nimrod, Glenview
31	Bob "Guess" Gesiakowski, Antioch	Adeline Jay Geo-Karis, Zion*
34	Joyce Holmberg, Rockford*	Terry Ingrassia, Rockford
37	James A. Narczewski, Spring Valley David D. Considine, Harmon	Calvin W. Schuneman, Prophetstown*
40	Liese L. Ricketts, Crete	Aldo A. DeAngelis, Olympia Fields*
43	Jerome J. Joyce, Reddick*	
46	Richard N. Luft, Pekin*	Robert "Bob" Haas, Pekin Merlin A. Kiesewetter, Creve Coeur
49	Vince Demuzio, Carlinville*	
52	William A. (Bill) Siler, Urbana	Stanley B. Weaver, Urbana*
55	David Vaught, Fairview Heights	Frank Watson, Greenville*
58	Paul Lionel "P.L." Parr, Buncombe Gary L. McClure, Chester Sydney H. Appleton, Murphysboro W.G. (Bill) Wheetley, Makanda	Ralph Dunn, DuQuoin

For Representative in the General Assembly

REPRESENTATIVE DISTRICT		
1	Alan J. Greiman, Skokie*	Lenore Picker Janecek, Lincolnwood
2	William J. Laurino, Chicago*	Gerald L. Lonski, Chicago Kenneth R. Hurst, Chicago Elmer C.W. Haneberg, III, Chicago
3	Claude A. Walker, Chicago Lee Preston, Chicago*	
4	Woody Bowman, Evanston*	Michael D. Poulos, Evanston
5	Ellis B. Levin, Chicago*	Donald G. Bagger, Chicago
6	Bruce A. Farley, Chicago* Buddy L. Myers, Chicago	Virginia V. Mann, Chicago
7	John Cullerton, Chicago*	

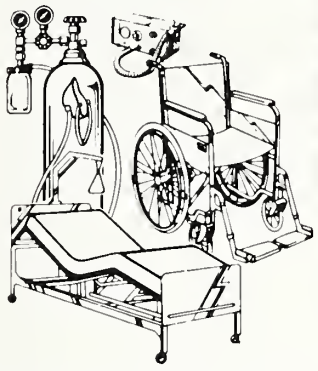
Representative District	Democratic	Republican
8	Jesse C. White, Jr., Chicago*	Marshall R. Crawford, Chicago
9	Joseph Berrios, Chicago*	
10	Myron J. Kulas, Chicago*	
11	Steven G. Nash, Chicago* William H. Bork, Chicago	Frank R. Ranallo, Chicago Richard Scimo, Chicago
12	Alfred G. Ronan, Chicago*	Jerry Phillips, Chicago
13	Ralph C. Capparelli, Chicago*	John P. Forde, Chicago
14	Timothy J. Johns, Norwood Park Leonard R. Goduto, Chicago	Roger P. McAuliffe, Chicago* Edward D. Kelley, Chicago
15	Robert LeFlore, Jr., Chicago* Andrew Martin Le Fevour, Oak Park James A. Elam, Sr., Chicago	Edward C. Vincent, Oak Park
16	James A. DeLeo, Chicago	Vito P. Cali, Elmwood Park Al DiSilvestro, Chicago
17	Anthony L. Young, Chicago Sharon Markette, Chicago* Clemintee Lindsey, Chicago	
18	Arthur L. Turner, Chicago* Albert D. Chesser, Sr., Chicago	Daniel A. Wolff, Cicero
19	Douglas Huff, Jr., Chicago* Ellen Augusta Barlow, Chicago Edward Allen, Jr., Chicago Carolyn A. Johnson, Chicago Joseph C. Sharpe, Chicago Ernest L. Thomas, Chicago Margaret Morris, Chicago Robert D. Conda, Chicago Oscar L. West, Chicago	
20	Juan M. Soliz, Chicago Marco Domico, Chicago*	
21	John M. Vitek, Chicago	William T. Margalus, Chicago
22	Robert T. Krska, Chicago	
23	Paula J. Mazique, Chicago Larry S. Bullock, Chicago* John E. Adams, Chicago Jeffery L. Roberts, Chicago Dan Dever, Chicago "Big" James Phipps, Chicago Muhuri Fahara, Chicago	
24	Sylvester O. Rhem, Chicago* Jerry Washington, Chicago Tom Young, Chicago	

Representative District	Democratic	Republican
25	Carol Moseley Braun, Chicago*	
26	Barbara Flynn Currie, Chicago*	
27	John J. McNamara, Oak Lawn	Herbert V. Huskey, Oak Lawn
28	James F. Keane, Chicago* Maurice E. Johnson, Chicago	Thomas V. Faragoi, Chicago
29	Thomas W. Murphy, Chicago Andrew J. McGann, Chicago*	
30	Michael J. Madigan, Chicago*	Leonard Kaczanowski, Chicago
31	James A. Moore, Jr., Chicago Peggy Smith Martin, Chicago Mary E. Flowers, Chicago	
32	Ethel Skyles Alexander, Chicago* Milton W. Hall, Chicago	
33	Nelson Rice, Sr., Chicago* Herman Madison, Chicago Raymond (Ray) V. Adkins, Chicago Anthony Spivey, Chicago	
34	James "Jim" Owens, Chicago David E. Jackson, Chicago Richard John Dowdell, Chicago William "Bill" Shaw, Chicago* Bobbie Ray Wilson, Chicago Robert Anderson, Chicago Gloria H. Allen, Chicago Arnold M. Jordan, Chicago	
35	Maurice V. Richards, Chicago Samuel Panayotovich, Chicago*	
36	Howard B. Brookins, Chicago* Dana Vincent Starks, Chicago Monique D. Davis, Chicago	
37	Stanley Rzadkowski, Homewood	John T. Doody, Jr., Homewood Loleta A. Didrickson, Flossmoor*
38		Jane M. Barnes, Palos Park*
39		Ralph Barger, Wheaton*
40	Truman Kirkpatrick, Lombard	Gene L. Hoffman, Elmhurst*
41		Mary Lou Cowlishaw, Naperville*
42		Suzanne L. "Sue" Deuchler, Aurora*
43	Lawrence G. Zdarsky, Berwyn John Hulbert, Berwyn	Jack L. Kubik, Forest Park
44		Thomas C. Sprague, Western Springs James R. Stange, Oak Brook

Representative District	Democratic	Republican
45		Kathleen L. "Kay" Wojcik, Schaumburg*
46		Lee A. Daniels, Elmhurst*
47	John T. O'Connell, Western Springs*	Charles W. Painter, Countryside
48	Robert M. Terzich, Chicago*	Florence Kielbasa, Chicago
49	Ronald G. Bobkowski, Schaumburg	Terry R. Parke, Hoffman Estates Elizabeth "Beth" Carpenter, Hanover Park
50		Donald N. Hensel, West Chicago*
51	Ted E. Leverenz, Maywood* Donna P. Felton, Broadview	Victor M. Pilolla, River Forest
52	Eugene C. Doyle, Northlake* John E. Brixy, River Grove	Linda-Jean M. Williamson, Northlake
53		David Harris, Arlington Heights*
54	Mary F. Korzen, Wheeling	Bernard E. Pedersen, Palatine*
55	Diana Burgess Sheffer, Park Ridge	Penny Pullen, Park Ridge*
56	Aaron Jaffe, Skokie*	Mannie H. Tucker, Skokie Jeffrey Stewart Shapiro, Wilmette
57	Carolyn Kleamenakis, Northfield	Bill Rodman, Glenview Margaret R. Parcells, Northfield Mark William Damisch, Northbrook Thomas D. Eilers, Winnetka
58	Grace Mary Stern, Highland Park	Hugh Sommerfeld, Wheeling Ron Nelson, Arlington Heights
59		Virginia Fiester Frederick, Lake Forest*
60		William E. Peterson, Buffalo Grove*
61	John S. Matijevich, North Chicago*	
62	Samuel E. Payne, Sr., Zion	Robert W. Churchill, Lake Villa*
63		Dick Klemm, Crystal Lake*
64		Ronald A. Wait, Belvidere*
65		Jill Zwick, East Dundee* Ed Brown, Algonquin Edwin L. Armstrong, Fox River Grove
66	Michael J. O'Malley, Hoffman Estates	James M. Kirkland, Elgin*
67		John W. Hallock, Jr., Rockford*
68	E.J. "Zeke" Giorgi, Rockford*	Robert A. Pfluger, Rockford
69	Richard T. "Dick" Mulcahey, Durand*	

Representative District	Democratic	Republican
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71	Joel Brunsvold, Milan*	
72	M. "Bob" DeJaegher, Silvis*	Keith Speckman, Port Byron David Allred, Moline Kathryn Railsback, Moline Simon Sierra, East Moline
73		A.T. "Tom" McMaster, Dahinda*
74	Richard A. Mautino, Spring Valley*	
75	Peg McDonnell Breslin, Ottawa*	Roy Rathbun, Streator
76	Jordan Gallagher, Sycamore	John W. Countryman, DeKalb
77	Frank Giglio, Calumet City* Delores Ryan, Lansing	Roy A. Leck, Jr., Lansing
78	Terry A. Steczo, Posen*	John E. Horn, Oak Forest
79	Alfred R. Ragonese, Lansing	Robert J. Piel, South Holland*
80	Jim Marzuki, Park Forest*	George C. Townsend, Park Forest Robert P. Regan, Park Forest South
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83	LeRoy Van Duyne, Joliet*	Pete June, Joliet
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87		Thomas W. Ewing, Pontiac*
88		Gordon L. Ropp, Normal*
89		Judy Koehler, Henry*
90	Joseph DiLillo, Lincoln	Sam Vinson, Clinton*
91	Thomas J. Homer, Canton*	
92	Donald L. Saltsman, Peoria*	
93		Fred J. Tuerk, Peoria*
94	Norman M. Winick, Galesburg	Carl E. Hawkinson, Galesburg*
95	David M. Dorgan, Lewistown Daryl "Pete" Thompson, Oquawka	Zack Stamp, Stronghurst Kent Slater, Macomb Wayne E. Rampley, Sutter

Representative District	Democratic	Republican
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98	John F. Sharp, Staunton Gary Hannig, Mt. Olive*	Craig S. Allen, Mt. Olive
99	Michael D. Curran, Springfield*	Dwight H. "Cap" O'Keefe, Springfield
100	Mike Southworth, Springfield	Josephine K. Oblinger, Auburn*
101	John F. Dunn, Decatur*	Denene Wilmeth, Decatur
102	John C. Curtin, Blue Mound	Michael J. Tate, Decatur*
103	Helen F. Satterthwaite, Urbana*	Linda S. Frank, Champaign
104	Katy B. Podagrosi, Rantoul	Timothy V. "Tim" Johnson, Urbana*
105	Larry R. Stuffle, Danville*	Harry "Babe" Woodyard, Chrisman* (Rep. Woodyard presently serves the 106th trict)
106	David Lee Weir, Mattoon Robert Webb, Mattoon	Michael "Mike" Weaver, Charleston Larry D. Stoever, Charleston
107	Richard H. Brummer, Effingham*	
108	Larry W. Hicks, Mt. Vernon*	Clyde W. Robbins, Fairfield
109	Gerald "Jerry" Sinclair, Salem	Dwight P. Friedrich, Centralia*
110	Michael "Mike" Slape, Pocahontas* Alan J. Dunstan, Troy	Ron Stephens, Caseyville
111	Sam W. Wolf, Granite City*	
112	Jim McPike, Alton*	
113	Wyvetter H. Younge, East St. Louis* Frank C. Smith, East St. Louis	
114	Monroe L. Flinn, Cahokia*	Ronald G. Steinhardt, Belleville
115	C. Herschel Williams, Sparta Victor O. Provart, Pinckneyville Willard "Will" Pugh, Pinckneyville	Delbert H. Hayer, Sparta Charles Wayne Goforth, Tamaroa
116	Bruce Richmond, Murphysboro*	
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First in a Series

Mandatory Reporting Amendments to the Medical Practice Act

At its September, 1983, meeting, the ISMS Board of Trustees endorsed a booklet detailing pertinent aspects of the January 1, 1983, mandatory reporting amendments to the Illinois Medical Practice Act. Development of the booklet had been a joint effort of ISMS, the Chicago Medical Society, the Illinois Hospital Association and the Chicago Hospital Council. A cooperative effort was considered appropriate as each group had a vital interest in the law, its proper administration and uniform understanding by those effected.

This feature is excerpted from that booklet (available in full through the ISMS offices). Readers will note reference to question numbers in the text: a complete set of questions will be published in next month's IMJ.

Information in this article is based upon input from representatives of the Illinois Department of Registration and Education and reflects the writers' understanding of the State's current approach to implementing and interpreting the law. However, readers are cautioned to consult their own attorneys when a situation arises which could affect them, as experience with the law may result in development of new rules after the publication date.

As a result of P.A.82-1036, the Medical Practice Act was changed as follows:

- The law now *requires* licensed health facilities, professional associations, malpractice insurers, states attorneys and public agencies to report physicians to the Medical Disciplinary Board under certain conditions.
- The statute of limitations was extended to permit the state one year from the day a suit is settled or ended in favor of a plaintiff to determine if a disciplinary action should be taken against the defendant physician. The previous provision required the state to take action within three years from the date of an alleged violation. The new amendment permits the state to wait until litigation is finished prior to beginning its investigation.
- The law now defines when a physician, previously disciplined by the state, may be deemed rehabilitated and eligible for reinstatement to full licensure;
- The law now requires the state to have rules defining certain criteria (unprofessional and immoral conduct, gross misconduct and gross malpractice) which, if proven, could result in a physician being disciplined. This amendment states that such definitions cannot be used in civil actions, but only for licensing or disciplinary purposes.
- An amendment was adopted to place two non-voting members of the public on the Medical Disciplinary Board, which currently is comprised of five medical doctors, one osteopathic physician and one chiropractor.

Definitions

The terms listed below are used throughout the law and rules. An understanding of their definitions is vital to effective compliance with the law. The definitions should be referred to when reading this document.

"Unprofessional Conduct"—The law defines "unprofessional conduct" as any conduct directly related to patient care which would constitute grounds for disciplinary action against a physician, as

described under both the Act and rules. The list of possible grounds is extensive.

"Mental or Physical Disability"—This phrase is defined as the inability of a physician to practice medicine with reasonable skill and safety, due to physical or mental disabilities, as evidenced by a written determination or written consent based on clinical evidence, including deterioration through the aging process, or loss of motor skills, or abuse of drugs or alcohol, of sufficient degree to diminish a person's ability to deliver competent patient care.

"In Lieu of Formal Action"—Neither the Act nor its rules presently define this phrase, therefore it is our suggestion that a hospital should review its medical staff bylaws and consult its attorney to determine when, for that facility, "formal action" begins, and when a report "in lieu of formal action" is appropriate. Ideally, no report would be made until the institution has reason to believe a physician's actions or conduct would result in the hospital taking an action which would require a report. The Department of Registration and Education anticipates drafting new rules to define "formal action."

"Impaired/Impairment"—This term has the same meaning as "mentally or physically disabled."

"Under Supervision"—This phrase means that the performance of an impaired physician's clinical privileges is being observed and monitored under the authority of a written directive issued in accordance with a health care institution's or medical staff's bylaws, rules and regulations. Consequently, the definition of "under supervision" must be determined separately by each hospital according to its own set of bylaws. Legal counsel should review the bylaws to determine whether the authority to place a physician under supervision is limited to the governing board or whether this authority has been delegated to the medical staff or department heads.

"Final Determination"—A "Final Determination" occurs when the governing body of an institution or association takes a final action, under its own procedures, against a physician. In practice, this would occur when all appeals provided for in the bylaws have been either completed or waived, and the physician has no further avenues, outside the courts, to prevent the institution or association from either restricting or terminating his or her privileges.

Reporting Requirements of Licensed Health Care Institutions

In general, the administrator of a hospital, nursing home, ambulatory surgical treatment center, home health agency or alcohol treatment center is required to submit a report to the Medical Disciplinary Board (MDB, Board) of the Department of Registration and Education within 60 days of the facility taking action to terminate or revoke a physician's privileges due to "unprofessional conduct" or "mental or physical disability," or when the facility places a physician "under supervision," due to a verifiable "impairment" which could endanger patients.

Reporting of Disciplined Physicians

Specifically, the law mandates that in the following situations a health facility must submit a report to the state:

(1) The governing body of the facility makes a "final determination," according to its own due process and hearing procedures in its bylaws, to terminate or restrict a physician's clinical privileges, due to a finding that the physician has committed an act constituting "unprofessional conduct," as defined by the law and its regulations.

(2) The governing body of the facility has made a "final determination" to terminate or restrict a physician's clinical privileges, due to a finding that the physician has a "mental or physical disability," and is endangering patients.

(3) A physician has accepted voluntary termination or restriction of privileges "in lieu of formal action" taken by the health facility to determine if the physician has committed "unprofessional conduct."

(4) A physician has accepted voluntary termination or restriction of privileges "in lieu of formal action" to determine if the physician has a "mental or physical disability" and is endangering patients. (See Question and Answer Section: #4, #5, #7, #8 & #12)

Reporting Impaired Physicians

The second part of the mandatory reporting provision requires a health care facility to submit a report when it has identified, through a written determination or written consent, based on clinical evidence, that a physician is "impaired," *and* the facility has placed that physician "under supervision." If appropriate, the facility would also report that it had helped the physician get into a program of rehabilitation. (See Question and Answer Section: #3 and #6)

Note: The state will investigate, for possible license suspension or revocation, a physician who has been disciplined by a facility. However, a physician reported as "impaired" *and* "under supervision" will only be monitored, to ensure that the physician's behavior and practice are being watched by the institution and an attempt is being made to bring the physician to normal functioning. (See Question and Answer Section: #15)

Making Reports

The state provides two distinct forms for reporting physicians, one for those who have been disciplined and one for those reported as "impaired" and "under supervision".

The key factors in determining which report to make are: 1) If the physician's privileges have been affected due to "unprofessional conduct" or disability, the physician is considered a disciplinary report; and 2) If the physician has been placed "under supervision"

following a determination of impairment, it is a report to be monitored.

- For example, if a physician has been found, through clinical tests, to be an alcoholic *and* has been placed "under supervision," the physician is considered "impaired", regardless of whether the physician also participates in a rehabilitation program. If that same physician's privileges have also been restricted, the state would still prefer the physician be reported on the impaired physician form, as long as the physician remains "under supervision." If a physician is found to be an alcoholic and goes to a treatment center, but is not placed "under supervision," or has not had privileges affected, no report is required.

The state has set up its entire reporting and data processing system to take advantage of the official forms, and therefore, requests that all reporting entities use the forms when a report is deemed appropriate.

Note: The official reporting forms *ask* for a number of items which are not required to be included by the law, but which the state believes will help facilitate a quick response to reports and which the state believes it has the right to ask for under section 16.04 b.6 of the law.

- For example, the state reporting form asks for the names, addresses and medical records of patients. However, Section 16.04 b.3 provides for the report to include "the name or other means of identification of any patient or patients whose treatment is a subject of the report, provided, however, no medical records may be revealed without the written consent of the patient or patients."

The state has indicated that if a report provides sufficient information to enable the Medical Disciplinary Board to reach a reasoned decision to close or investigate a case, there will be no need to contact a doctor's patients, whose care was a factor in the report being filed, for authorization to release their medical records. However, if a full investigation is deemed necessary, patients may be contacted by the department. If consideration is being given to providing more information than is required by the law, we recommend the reporting entity consult its legal counsel prior to doing so. (See Question and Answer Section: #16)

All forms are to be sent to the Mandatory Report File Custodian (Medical Disciplinary Board, Illinois Department of Registration & Education, P.O. Box 7006, Springfield, IL 62791) within 60 days after determining a report is required under the law. The envelope containing the report is to be marked "Personal and Confidential."

Disciplined Physician Report

The law requires that the following information be included in this type of report: (a) name, address, phone and facility of the person making the report; (b) name, address, phone, and license number of the physician subject to the report; (c) name(s) of or other means of identification of the patient(s) whose case(s) served as a basis for action being taken against the physician, and the date(s) of that care. [Note: The official form asks that medical records be attached as appropriate but the law states that medical records cannot be released without patient authorization. (See Question and Answer Section: #19)]; (d) type of action taken by the facility; (e) description of the incident(s) or conduct constituting unprofessional conduct or mental or physical disability; (f) date of the final determination and the length of the restriction, along with any appropriate documents; (g) whether the act(s) resulted in any court actions; and (h) any other pertinent information which the reporting party deems to be an aid in the evaluation of the report.

Impaired Physician Report

The official Impaired Physician Report Form requires the following information: (a) name, address, phone and facility of the person making the report; (b) name, address, phone and license number of the impaired physician; (c) means of identifying patient(s) whose cases led to the report and the date(s) of that care (The law's rules reserve the right for the state to obtain patient names and addresses); (d) the type of action taken by the facility; (e) description of the impairment; (f) the terms and conditions of the supervision under which the subject of the report is conducting his activities or practice (This includes the date supervision commenced, the term of the supervision, the name, address and telephone number of the person in charge of the subject's supervision, and a written consent executed by the subject of the report, authorizing the Board, the Medical Coordinator or other designated representative of the Board to contact the person in charge of the subject's supervision for information, including written documentation, in order to evaluate the progress of the subject's supervision.); (g) name, address, phone of person running the physician's rehabilitation program (The state will contact the rehabilitation program for detailed information on how the impaired physician will be treated) and (h) any other information deemed by the reporting person to be of assistance to the Board.

It's important to again emphasize that before an impaired physician report is filed the physician considered "impaired" *must* have been placed "under supervision" by the facility, *and* the impairment clinically verified, even if admitted to by the physician. This information will help the facility design an appropriate supervision.

Once an impaired physician is reported, the state will notify in writing the individual making the initial report of the date each subsequent report is due regarding the physician's progress under the supervision. If the physician is also in rehabilitation, the rehabilitation director will be contacted directly by the state. The rehabilitation program is not required to submit reports. Reports are to be filed with the Disciplinary Board by the hospital every six months. The physician

being supervised or treated is to receive copies of the monitoring report from the originator of that report. Should the MDB determine that status reports on an impaired physician are no longer needed, the maker of the reports will be so notified. In such a situation the reports already filed with the state will be destroyed.

Administrative Violations
Disciplinary actions taken against a physician due to violation of administrative provisions of the facility's or staff's bylaws, rules or regulations are not required to be reported under the law, as long as the violation is not directly related to patient care. (See Question and Answer Section: #12)

Confidentiality of Reports
The contents and reports themselves are strictly confidential and will be handled only by members of the MDB and authorized state staff. The only other persons having knowledge of the report will be the person making the report and the subject, who will receive a notification of any report filed with the state under this law. A physician who wants his or her attorney to receive a copy of the report will be asked by the state to submit a written, notarized authorization for releasing this information.
Information contained in a report on an impaired physician cannot be used in any other administrative or legal proceeding and is not discoverable nor subject to subpoena. Additionally, the confidentiality of any medical records is to be maintained. (See Question and Answer Section: #18 and #20)

Immunity for Those Participating in the Reporting Process
The law provides immunity from criminal and civil prosecution to any organization or person involved in making a report or providing information or assisting in the determination that a person has committed unprofessional conduct, is mentally or physically disabled, or is impaired, as long as the organization or person was acting in good faith and not in a willful and wanton manner.

Reporting by Professional Associations

The president or chief staff person of a national, state, county or city professional association of physicians, operating in Illinois, is required to report to the Board when the association's governing body renders a "final determination" that a member of that group has committed "unprofessional conduct," as defined by the law, or may be "mentally or physically disabled" in such a manner as to endanger patients under the physician's care, and the association has taken action affecting that physician's membership status.

The report to be filed is essentially the same as that for health facilities. The confidentiality and immunity provisions previously discussed also apply to professional associations. Physicians the association has identified as needing help, but who are not being disciplined, need not be reported.

Reporting by Professional Liability Insurers

In 1983, the Illinois General Assembly amended the law to expand the original reporting requirements by professional liability insurers. The law now requires every insurance company offering professional liability insurance or any other entity which indemnifies the professional liability of a person licensed under the Act to report to the MDB the settlement of any claim or cause of action, or final judgment rendered in any cause of action which alleged negligence by the physician, when the settlement or final judgment was in favor of the plaintiff.

The reporting form for such entities *asks* for information about the cases, previous suits involving the physician and awards paid out. While the law does not require that this information be provided, the state believes this information is important to their deciding whether to further investigate the report, and they have authorization to request such information under Section 16.04 b.6.

Reporting by States Attorneys

The States Attorney of each county is required to report to the MDB all instances in which a physician is convicted or found guilty of committing a felony.

Reporting by Public Agencies

An agency, department, or commission affiliated with the State of Illinois is required to report to the Board any instance arising in connection with the operations of the agency, including its administration of any law, where it finds a physician has committed an act which may be: 1) in violation of the Medical Practice Act; 2) unprofessional conduct directly related to patient care or, 3) an indication that the physician is "mentally or physically" disabled in such a manner as to endanger patients.

Deliberations of the Medical Disciplinary Board (MDB)

Once a report has been received by the MDB's Mandatory Report File Custodian, the Board has thirty days to notify, by certified mail, the physician who is the subject of the report. The physician is to be notified of the right to examine the report's contents and to submit a written statement clarifying, adding to or proposing amendments to the report. The physician should write to the MDB and request a copy of the report since a copy will not automatically be sent to the subject.

Following a receipt of this notification, the physician has 30 days to submit, if desired, a response to the MDB.

On the 61st day after the MDB has received a report on a physician, the Board may begin reviewing the information submitted by the reporting entity and the subject physician. The law then states that the MDB has sixty days to determine if there are sufficient facts to warrant further investigation, or if the report should be filed and the matter closed.

If no decision has been reached at the end of 120 days after the original report was received by the state, the matter is considered closed. In reviewing the facts of a report, the MDB has two options: 1) it may close the matter, or 2) it may request further investigation to gather additional materials.

The maker of the report and the physician who is the subject of the report will be notified in writing of any final action taken by the MDB.

Summary Reports

The law now provides for the state to create a report every other month of final actions taken upon disciplinary files maintained by the MDB. This report is to be sent to all licensed facilities, state professional associations, the American Medical Association, professional liability insurers, the Federation of State Licensing Boards and the Illinois Pharmacists Association. (See Question and Answer Section: #18)

Penalties for Violating the Law

Any violation of the mandatory reporting provisions can result in a Class A misdemeanor, a penalty providing for imprisonment of less than one year and/or a fine not to exceed $1000. In addition, the Attorney General is empowered to bring an order enforcing compliance with the law. Anyone violating such an order could be found in contempt of court and be punished by the court. ◀

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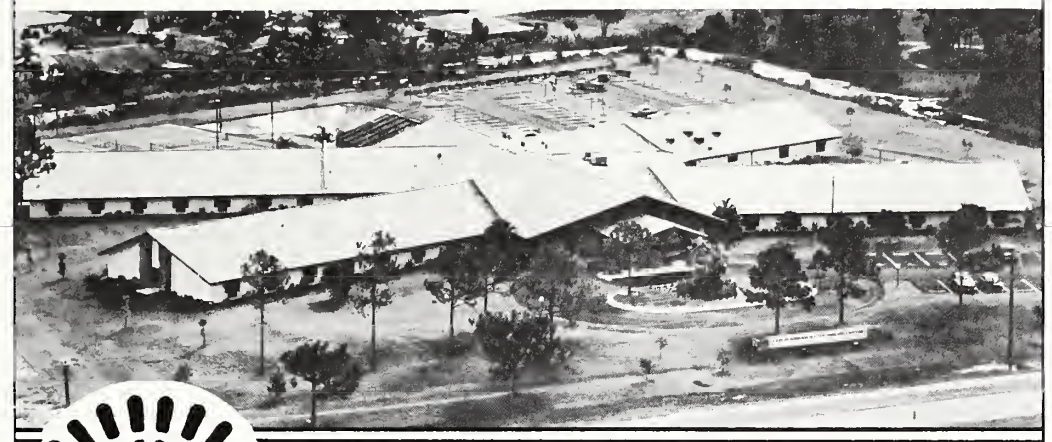
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Convention

By Susanne Webb, ISMSA President

As the annual meeting approaches, April 6-7, 1984, it would be well to review the business that, according to our bylaws, must be transacted at the meetings of the House of Delegates. First of all, the budget must be approved. The budget is drawn up by the Finance Committee which consists of the finance chairman, the treasurer, the president, the president-elect and one board member appointed by the president. The proposed budget is approved by the Board of Directors prior to convention and is voted upon by the House of Delegates. This year's budget will be very similar to that of last year, since the Board of Directors is working diligently to be fiscally responsible.

A second item of business is the election of officers. A slate of nominees for all offices is presented by the Nominating Committee. Nominations for any office may be made from the floor of the House of Delegates with the consent of the nominee. These elections are democracy in action.

A third item of business on the agenda is the election of the Nominating Committee. This is a very vital and extremely responsible job because the five members of the Nominating Committee are the ones who select the slate of officers for the organization for the next year. According to our bylaws the members of the committee are elected as follows: "elect one member and two alternates from the Board of Directors and three members and three alternates from the registered delegates not serving on the Board who are from a district other than that of the immediate past president" (the immediate past president is automatically a member of the committee). It is important to keep in mind that all five members of the Nominating Committee itself must be from different districts. The alternates may be from any district.

The fourth item is the election of the delegates to the annual meeting of the AMA Auxiliary. The president, president-elect and immediate past president are automatic delegates and the total number is based upon total state membership: one delegate for each 300 members or major portion thereof. This meeting is a good time for the sharing of ideas and camaradarie.

It has become traditional to have the president-elect of the AMA Auxiliary at convention. This year Billie Brady of South Carolina will be the keynote speaker and give us a preview of the direction in which the AMAA will be moving in the coming year. The other speaker will be Margaret Dykinga whose topic will be "Women and Power" including power defined, characteristics of a powerful person, how women stop themselves from being powerful, "powerful" responses to any situation and contracting for change.

There will be time for shopping in Chicago's great stores, dining in Chicago's fine restaurants and sharing ideas, opinions and experiences with fellow auxilians. Come and enjoy!

ISMS STUDENT LOAN FUND ACTIVITIES

Over the last two years, the Education and Scientific Foundation of the Illinois State Medical Society has developed a special student loan fund for Illinois medical students attending any of the eight medical schools in the state. Thanks to the concerted effort and generosity of the ISMS membership, the loan program has advanced to where, in this academic year, the Foundation was able to provide $50,000 in much needed loan funds.

While ISMS is pleased with progress in providing student loans this past year, including the successful fund raising auction at the 1983 Annual Meeting, it is necessary to keep the positive momentum going. During 1984, ISMS will offer its membership additional opportunities to contribute to the ongoing success of this worthwhile program. When the time comes, please give generously of your energy and resources to ensure that educational funding will be available for the next generation of Illinois physicians.

EKG

(Continued from page 107)

Answers: 1. C 2. A, B, C, D, E

The ECG shows a rate of 145 beats per minute with a normal QRS duration. There are inverted P waves in leads II, III, AVF, and V_2 through V_6 ruling out sinus rhythm. Slight ST segment elevation is seen in leads II, III and AVF. This is an atrial tachycardia with a P wave, vector oriented superiorly, leftward, and posteriorly. There are no flutter waves present. The immediate concern in the emergency room was the significance of this tachycardia in light of his apparently atypical seizure. Intravenous digoxin was used and readily converted the tachycardia to normal sinus rhythm. It recurred the next day and was broken with a Valsalva maneuver. Over the next several days, the atrial tachycardia erupted several times but did not precipitate any significant symptoms or seizures. A repeat electroencephalogram was normal and review of the old electroencephalograms demonstrated normal varients. The neurological exam and a CT scan of the brain were normal. Our neurology consultant recommended no treatment. Since neither digoxin nor propranolol controlled *and* prevented the tachycardias, an electrophysiologic study was recommended. The atrial tachycardia appeared to be an atrioventricular (AV) reentrant tachycardia and was easily induced or interrupted by one or two premature atrial extrastimuli. Over several days, the tachycardia could easily be induced even though the patient took digoxin, propranolol, disopyramide, and quinidine individually in therapeutic doses. Although intravenous verapamil is now considered the drug of choice for immediate conversion of atrial tachycardia, it did not prevent recurrences in this patient. Finally, a combination of digoxin and quinidine appeared to be the best choice for control of the tachycardia. Blood levels of these two drugs were carefully monitored. No further seizure activity was recorded over the next year. ◂



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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Registration and Education (R&E)

ISMS has been advised that the following physicians have been disciplined by the Department of Registration and Education in the months of November and December:

November Orders

- *Philip C. Gradolph, MD.:* On November 21, 1983 an order was signed suspending for 60 days, beginning October 31, 1983, the license of Dr. Philip C. Gradolph, license #036-038693. In addition, his Controlled Substance license was revoked.
- *Samuel Matlin, M.D.:* On November 21, 1983, the license of Dr. Samuel Matlin, license #036-31534, was restored and was placed in a probationary status until December 31, 1985. Dr. Matlin's license was suspended on September 16, 1983.
- *Luis G. Perez-Reyes, M.D.:* Effective December 2, 1983, the license of Dr. Luis G. Perez-Reyes, license #036-39088, was suspended indefinitely. He was permitted to work only at the Salvation Army Freedom Clinic, at no compensation.
- *Nicholas C. Pineda, M.D.:* On November 2, 1983, the license of Dr. Nicholas C. Pineda, license #036-44946, was reprimanded.

December Orders

- *Henry A. Hanelin, M.D.:* On December 2, 1983, the license of Dr. Henry A. Hanelin, license #036-021094, was suspended.
- *Laurence Heineman, M.D.:* On December 29, 1983, the license of Dr. Laurence Heineman, license #036-040350, was placed on probationary status for a one year period. His license was also restricted to prohibit him from engaging in the practice of obstetrics.
- *Stewart Marcowitz, M.D.:* On December 13, 1983, the license of Dr. Stewart Marcowitz, license #036-53145, was reprimanded.
- *Andrew Miesz, M.D.:* On December 6, 1983, the license of Dr. Andrew Miesz, license #036-042820, was restored with the following restrictions: 1) He cannot practice surgery or obstetrics or gynecology; 2) He can practice only in a supervised setting for at least the next 2 years; and 3) His license was placed under probation for a two year period.

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago IL 60603.

BEARDSTOWN:
Population of 7,000 with a service area of 30,000. Located 45 miles from Springfield. Under contract management of Memorial Medical Center. New three person medical office building. First year guaranteed income plus other benefits. Recreational facilities nearby. CONTACT: Jeffrey L. Martin, P. O. Box 350, Beardstown 62618. (217) 323-2720. (4)

BREESE:
Serving population 25,000. Need family practice physician for Carlyle (8 miles from hospital). Financial assistance available. 40 miles east of St. Louis, near Carlyle Lake. Excellent recreational opportunities. Quality schools and colleges in area. Contact: Sr. Mary Anthony, St. Joseph's Hospital, Breese, 62230. (618) 526-4511. (3)

BREESE:
Serving population 25,000. 40 miles east of St. Louis, near Carlyle Lake. Need OB-Gyn physicians to share practice with present OB-Gyn physician. Need family practice. Quality schools and colleges in area. Financial assistance available. CONTACT: Sr. Mary Anthony, St. Joseph's Hospital, Breese, 62230, (618) 526-4511. (3)

DU QUOIN.
Orthopedic surgeon needed for clinic and surgical services. Fully equipped office adjacent to X-ray and emergency. Complete support services in house. Excellent opportunity in rural medicine. 20 miles from SIU-Carbondale. Beautiful community 70 miles southeast of St. Louis. David R. Hosler, Administrator, Marshall Browning Hospital, Du Quoin 62832, 618-542-2146. (4)

GLEN ELLYN:
Internist to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. Contact: Dave Bauer, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave. Glen Ellyn 60137, 312-469-9200. (5)

LINCOLN:
Openings for two family practitioners and one OB/GYN in central Illinois. Local hospital is a progressive 133 bed community hospital with a population base of 40,000, in a two county area. Lincoln is a hub for five major cities that have major universities, tertiary care centers, shopping, recreational and cultural activities. Contact D. David Sniff, Administrator, Abraham Lincoln Memorial Hospital, Lincoln 62656, 217-732-2161. (3)

MATTOON:
Primary care physicians needed for tri-county clinic. Attractive East Central Illinois community. Financial startup package. Access to university towns. Anesthesiologists needed for six year old 210 bed JCAH approved hospital. Send C.V. to Bill Rauwolf, SBLHC, P.O. Box 372, Mattoon 61938. 217-258-2577. (4)

MOUNT CARROLL:
G.P./Family Practice, solo practice. M.D. back up available, plus eleven EMTs on local ambulance crew. Small, historic, county seat community in unglaciated portion of northwest Illinois, ten miles east of Mississippi River. Great outdoor recreation, strong sense of community. Financial assistance available. Office space remodeled to suit. Excellent hospital facilities nearby. Contact: Laurie Scott, 302 N. Main., Mount Carroll, 61053. 815-244-1379;244-1407 (H). (5)

MONMOUTH:
Family practice physician needed immediately to assume well established practice in thriving Illinois agricultural community. 15 minutes from 91-bed JCAH accredited hospital with range of support services. Major university, private college and recreational facilities nearby. Submit C.V. to Victoria Hennenfent, Community Memorial Hospital, Monmouth, 61462. 309-734-3141. (3)

PITTSFIELD:
Population 4,200; County: 19,500.

67 bed JCAH accredited hospital completing $2 million addition/ renovation in May 1984. Ten active staff members at present. Openings in Family Practice and General Surgery. 75 miles west of Springfield between Illinois and Mississippi Rivers. Recreational facilities abound. Contact: Fred Thompson, 640 W. Washington Street, Pittsfield, 62363, 217-285-2113. (5)

SALEM:
Population 7,800. 70 miles east of St. Louis, immediately off I-57. Need OB-GYN physician to join existing corporation or to practice independently. Existing corporation provides renovated office building less than five minutes from 65 bed JCAH accredited hospital. Guaranteed salary. Contact: Thomas G. Walther, Adm., Salem Hospital, Salem, 62881, 618-548-3194. (4)

STREATOR:
Community of 22,000, serving population area of 70,000. Located 60 miles from Joliet and Peoria. Fully equipped hospital of 248 beds, with 41 physicians on staff. Cardiology, psychiatry and family practice specialities needed. Practice guarantees provided. Interested physicians are asked to send current resumes to: Terence Schuessler, Adm., St. Mary's Hospital, 111 Spring Street, Streator 61364. (4)

Effective Communication

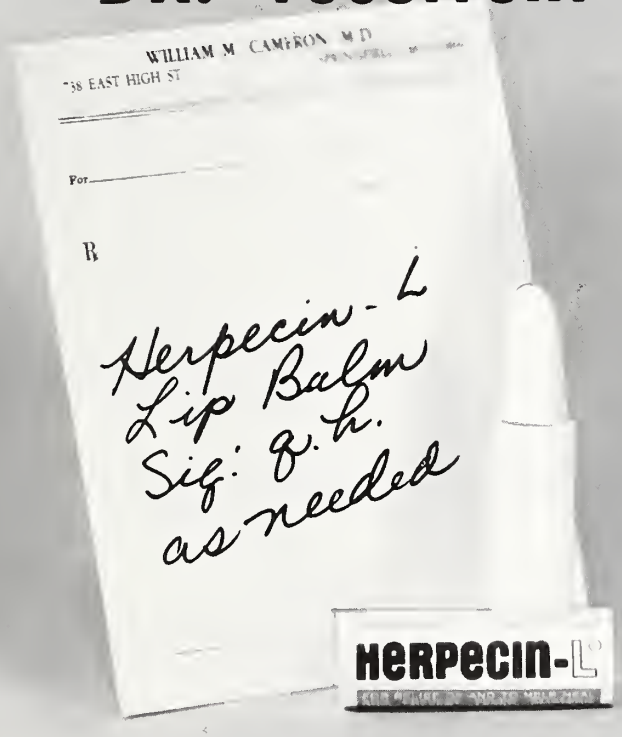
(Continued from page 106)

tation, not to replace it. If you are unsure, you can always paraphrase the slide information without boring the audience. By not reading to the audience you will not only be more relaxed and natural sounding, but you will be free to maintain eye contact. Even though you may not be able to see the last row, they can see you. The fact that your head is up and looking around the room, creates a bond or link between speaker and listener. This involves the audience and ensures their attention. It also prevents or reduces "stage fright". By this point you should be so familiar with your topic and your slides that you can concentrate on the audience as individuals. Your presentation should be as routine as conversation over coffee.

If your topic is worth presenting, you owe it to yourself and your audience to do a good job. With these simple tricks and hints anyone can become an effective speaker. A good speech is worth the effort, and you will be rewarded by knowing that your ideas have been understood by a wide awake audience. ◀

Roger P. Smith, M.D., is a board certified obstetrician and gynecologist affiliated with the Carle Clinic Association in Urbana. A clinical assistant professor, University of Illinois School of Clinical Medicine, Dr. Smith is a fellow of the American College of Obstetricians and Gynecologists. He is also secretary and former program director for the Illinois Obstetrical and Gynecological Society.

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MARCH

Licensure

State & National Board Review, Clinical
For: MD's taking State Licensure Exams. Lecture, Mar. 26-31, Chicago **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510.00. **Reg. Limit:** Max. 90. **Credit:** Category 1, 56 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800.

State & National Board Review, Basic
For: MD's taking State Licensure Exams. Lecture, Mar. 19-25, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510.00 **Reg. Limit:** Max. 90. **Credit:** Category 1, 62 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-733-2800.

Dermatology

Pediatric Dermatology
For: MD's. Lecture, Mar. 19-21, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $280.00. **Reg. Limit:** Max 55. **Credit:** Category 1, 21 hours. **Contact:** Robert J. Baker, MD **Phone:** 312-733-2800.

Psychiatry

Specialty Review in Psychiatry
For: Psychiatrists & Neurologists. Lecture, Mar. 12-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480.00. **Reg. Limit:** Max 55. **Credit:** Category 1, 45 hours. **Contact:** Robert J. Baker, MD **Phone:** 312-733-2800.

Comprehensive Psychiatry Review Part I: Basic Considerations
For: Psychiatrists. Course, Mar. 12-17, Chicago. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, 60637. **Fee:** $450.00. **Reg. Limit:** None. **Credit:** Category 1, 42 hours. **Contact:** Mary Ann Dillon **Phone:** 312-962-1056.

Medicine

Seizure Symposium
For: MD's. Symposium, March 16, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA. AAFP Prescribed TBA. **Contact:** Lorraine Stephenson **Phone:** 217-782-7711.

Choosing & Using a Computer in a Private Medical Practice
Lecture, March 23-24, 8am-5pm, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295.00. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Dr. Ben B. Blivaiss. **Phone:** 312-578-3215.

Surgery

Surgery Visiting Professor Lecture Series
For: MD's Lecture, Mar. 14, 8am-5pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215.

Ophthalmology

8th Annual Ophthamology Current Concepts Seminar '84
For: Ophthamologists & RN's. Conference with workshops, March 22-24, Madison, Wisconsin. **Sponsor:** University of Wisconsin, School of Medicine, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** none. **Credit:** Category 1, TBA. **Other:** UW-Extension, Continuing Education Units, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Pulmonary Diseases

3rd Annual Symposium on Chronic Obstructive Pulmonary Diseases
For: MD's, PT's. Symposium, Workshops, Mar. 8-9, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** none. **Credit:** Category 1, TBA. **Other:** UW-Extension, Continuing Education Units, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Coronary Artery Disease

Recent Advancement in Treatment of Coronary Artery Disease
For: MD's. Symposium, March 8, 1pm-5pm, DuQuoin, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, 62708. **Fee:** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours, AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephensen **Phone:** 217-782-7711.

Family Medicine

Medical Seminar-At-Sea
For: MD's. Seminar, March 15-25, Caribbean Sea. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 36 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Pathology

Hormonal Pathology of the Endometrium
For: Pathologists & Clinical Chemists. Symposium, Mar. 19 at 7:00 pm, Chicago, Drake Hotel. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central Ave., Chicago, 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, M.D., S.C. **Phone:** 312-626-4300 ext. 5720.

Practice Management

Choosing & Using a Computer in a Private Medical Practice
Lecture, Mar. 9-10, 8am-5pm, San Antonio, Texas. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295.00. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215.

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APRIL

Practice Management

Choosing and Using a Computer in a Private Medical Practice
For: MD's. Lecture, Apr. 13-14, 8am-5pm, Atlantic City. **Sponsor:** University of Health Sciences/The Chicago Med. Sch., 3333 Green Bay Road, North Chicago. **Fee:** $295. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215.

Anesthesiology

Specialty Review in Anesthesiology
For: Anesthesiologists. Lecture, Apr. 29-May 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, 60612. **Fee:** $590. **Reg. Limit:** None. **Credit:** Category 1, 54 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800.

Rehabilitation

10th National Conference on Case Resolution of Complex Industrially Injured
For: MD's, Therapists. Conference, Apr. 26-27, Paper Valley Hotel, Appleton, Wisconsin. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA, University of Wisconsin-Extension CEU's, TBA. **Sponsor:** University of Wisconsin-Ext., CME, 465b WARF Bldg., 610 Walnut St., Madison, 53705. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Radiology
Specialty Review in Radiology
For: Radiologists. Lecture, Apr. 2-6, Chicago. **Sponsor:** Cook County Graduate Sch. of Med., 707 South Wood St., Chicago, 60612. **Fee:** $450. **Reg. Limit:** None. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800.

Urology
Specialty Review in Urology
For: Urologists. Lecture, Apr. 2-7, Chicago. **Sponsor:** Cook County Graduate Sch. of Med., 707 South Wood. St., Chicago, 60612. **Fee:** $510. **Reg. Limit:** None. **Credit:** Category 1, 53 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800.

Gynecology, Oncology
Current Management of Problems on Gynecology and Gynecologic Oncology
For: Gynecologists, Oncologists. Course, Apr. 13-14, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, 60637. **Fee:** $195, res. $100. **Reg. Limit:** None. **Credit:** Category 1, 9 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Endocrinology
Clinical Endocrinology Conference
For: Endocrinologists. Course, Apr. 14, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, 60637. **Fee:** TBA **Reg. Lim.** None. **Credit:** Category 1, 7 hours. **Contact:** Mary Ann Dillon, **Phone:** 312-962-1056.

Pathology
Selected Topics in Surgical Pathology
For: Pathologists & MD's. Lecture, Apr. 2-6, 8am-5pm, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison, Chicago, 60612. **Fee:** TBA. **Reg. Lim.** None. **Credit:** Category 1, 32 hours. **Contact:** Linda Mays. **Phone:** 312-738-1336.

Cytology of Conduloma & Cervical Intraepithelial Neoplasia
For: Pathologists & Clinical Chemists. Symposium, Apr. 9, 7:00 pm, Chicago, Drake Hotel. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central, Chicago, 60644. **Fee:** Yes. **Reg. Lim:** None **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312-626-4300 ext. 5720.

The Myeloproliferative Disorders: A Multidisciplinary Approach
For: Pathologists. Lecture, Apr. 23-27, 8am-5pm, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison, Chicago, 60612. **Fee:** TBA. **Reg. Lim.:** None. **Credit:** Category 1, 33.5 hours. **Contact:** Linda Mays. **Phone:** 312-738-1336.

Specialty Review in Pathology: Anatomic
For: Pathologists. Lecture, Apr. 23-28, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, 60612. **Fee:** $480. **Reg. Lim:** 90. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD **Phone** 312-733-2800.

Specialty Review in Pathology: Clinical
For: Pathologists. Lecture, Apr. 30-May 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, 60612. **Fee:** $450. **Reg. Lim:** 90. **Credit:** Category 1, 41 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Surgery
Flexible Fiberoptic Sigmoidoscopy
For: MD's Lecture, Apr. 14, Chicago. **Sponsor:** Cook County Grad. Sch. of Med., 707 S. Wood, Chicago, 60612. **Fee:** $125. **Reg. Lim.:** 75. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

Advanced Peripheral Vascular Surgery
For: MD's Lecture, Apr. 16-20, Chicago. **Sponsor:** Cook County Grad. Sch. of Med., 707 S. Wood, Chicago, 60612. **Fee:** $390. **Reg. Lim.:** 90 **Credit:** Category 1, 34 hours. **Contact:** Robert Baker, MD **Phone:** 312-733-2800.

Surgery Visiting Professor Lecture Series
For: MD's Lecture, Apr. 18, 8am-5pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago. **Fee:** None. **Reg. Lim.:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, MD. **Phone:** 312-578-3215.

Fiberoptic Colonscopy
For: MD's Lecture, Apr. 25-27, Chicago. **Sponsor:** Cook County Grad. Sch. of Med., 707 S. Wood, Chicago, 60612. **Fee:** 450. **Reg. Lim.:** 20 **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD **Phone:** 312-733-2800.

Fiberoptic Esophagogastric Endoscopy
For: MD's. Lecture, Apr. 30-May 2, Chicago. **Sponsor:** Cook County Grad. Sch. of Med., 707 S. Wood, Chicago, 60612. **Fee:** $450. **Reg. Lim.:** 15 **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD **Phone:** 312-733-2800.

Psychiatry
Electroconvulsive Therapy—1984 Update
For: MD's, Nurses, Mental Health Prof. Conference, Apr. 6-7, Sheraton Inn, Madison, Wis. **Sponsor:** Center for Affective Disorders, Dept. of Psy., 600 Highland Ave, B6/255 Madison, WI 53575. **Fee:** $200 MD's, Nurses, Mental Health Prof.; $100 Res. and Trainees. **Reg. Lim.:** 200 **Credit:** Category 1, 10 Hours, 1.0 CEU Univ. of Wis. Ext., CME. **Contact:** Dorothy B. Davidson, Ph.D. **Phone:** 608-263-6129.

Oncology
Advances in Breast, Genitourinary, and Esophageal Cancer Therapy
For: GP, FP, urol, gen. surg. Course, Apr. 18, Chicago. **Sponsor:** University of Chicago, 5841 South Maryland, Box 139, Chicago 60637. **Fee:** None. **Reg. Lim.:** None. **Credit:** AMA Category 1, 6.5 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

MAY

Cardiac Rehabilitation
7th Annual Symposium: Cardiac Rehabilitation—Update 1984
For: MD's, Nurses, Therapists, Allied Health Prof. Symposium, May 1-4, Milwaukee Wisconsin. **Sponsor:** University of Wisconsin, Extension, CME, 465b WARF Bldg.; 610 Walnut St., Madison, Wisconsin 53705. **Fee:** TBA. **Reg. Lim.:** None. **Credit:** Category 1, 28 hours, 28 University of Wisconsin CEUs. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Neuroradiology
1984 Neuroradiology Review Course
For: Rad, Neuroradiologists, Neurosurgeons, Residents. Course, May 5-6, Oak Brook, Illinois. **Sponsor:** Loyola University Medical Center CME and Section of Neuroradiology, 2160 South First Avenue, Maywood, Illinois 60153. **Fee:** $140, $80 for Residents. **Credit:** Category 1, 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** 312-531-3237.

Medical Education
Teaching Clinical Competence
For: MDs, Workshop, May 7-8, Springfield, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** TBA. **Reg. Lim.:** TBA. **Credit:** Category 1 TBA. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Diagnosis and Treatment of Clinical Performance Problems
For: MDs. Workshop, May 9-10, Springfield, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** TBA. **Reg. Lim.:** TBA. **Credit:** Category 1 TBA. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Surgery
The Development and Current Concepts of the Gastrinoma Syndrome
For: MDs. Lecture, May 9, 8am-5pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, Department of Surgery, 3333 Green Bay Road, North Chicago. **Fee:** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215.

Pathology
Annual Slide Seminar: Problems in GI and Endoscopic Biopsies
For: Pathologists and Clinical Chemists. Symposium, May 14, 7pm, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 South Central Avenue, Chicago, Illinois 60644. **Fee:** TBA. **Reg. Lim.:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall H. Short, M.D., S.C. **Phone:** 312-626-4300, Ext. 5720.

Morphologic Approach to Blood Disorders
For: Pathologists. Lecture, May 14-18, 8am-5pm, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 West Harrison Street, Chicago, Illinois 60612. **Fee:** TBA. **Reg. Lim.:** TBA. **Credit:** Category 1, 32 hours. **Contact:** Linda Mays. **Phone:** 312-738-1336.

Radiology
Nuclear Magnetic Resonance, Computed Tomography, and Digital Radiology
For: Radiologists, Med. Physicists. Conference, May 15-18, Chicago. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg.; 610 Walnut Street, Madison, Wisconsin 53705. **Fee:** TBA. **Reg. Lim.:** TBA. **Credit:** Category 1, 25 hours, University of Wisconsin CEUs, 25. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Psychiatry
Comprehensive Psychiatry Review Part II: The Psychiatric Interview
For: Psychiatrists. Course, May 18-20, Chicago. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $325. **Reg. Lim.:** None. **Credit:** Category 1, 17 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Neurology
Stroke: Diagnosis, Prevention, Treatment
For: GP, Internists, Neurologists. Lecture, May 19, 8am-1pm, Urbana. **Sponsor:** Carle Foundation Hospital, Department of Medical Education, 611 West Park Street, Urbana, Illinois 61801. **Fee:** $35. **Reg. Lim.:** TBA. **Credit:** Category 1, 4.5 hours, AAFP Elective, 4.5. **Contact:** Deborah C. Rugg. **Phone:** 217-337-3022.

OB/GYN
Dysfunctional Uterine Bleeding and Evaluation and Treatment of Infertility
For: MDs, Office Staff. Symposium, May 24, 1pm-5:20pm, Pickneyville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $45. **Reg. Lim.:** None. **Credit:** Category 1, 4 hours, AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Practice Management
Choosing and Using a Computer in Private Medical Practice
For: MDs. Lecture, May 25-26, 8am-5pm, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, Illinois 60064. **Fee:** $295. **Reg. Lim.:** TBA. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215.

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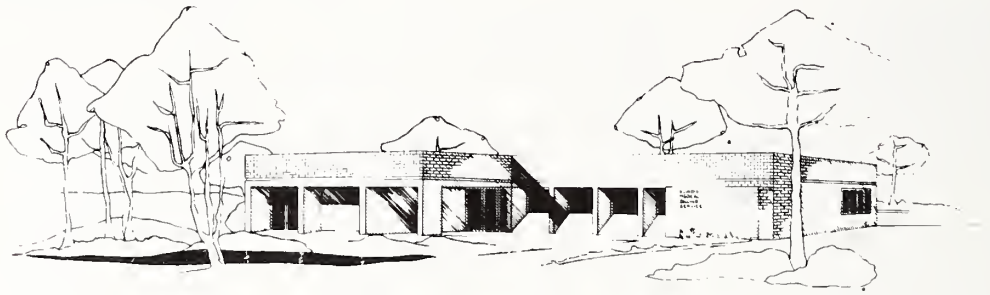
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Past Is Prologue



As I put thought to words in preparation for this, my last President's Page, I could not avoid the environment of my home city. Living in Lincoln country provides daily reminders of the homely philosophy of Abraham Lincoln, our sixteenth president. When he made the Gettysburg address, the final portion of his last statement spoke to the need of a nation "and that government of the people, by the people, for the people, shall not perish from the earth." I am going to take an editorial liberty and paraphrase this statement in accord with the title of this article: "Medical care of the people, by the people statutorily licensed, for the people seeking care for their needs, shall not perish from the earth."

A basic premise permeates this idea: medical care is delivered by physicians. However, one must be realistic and understand the milieu in which our profession delivers present day medical care. Traditionally, we feel that patients want personal care. Physicians need to be committed to delivering personal care if they feel this to be the underlying premise of the policy of free choice for patient and physician. Recent polls have indicated a willingness among patients to opt for convenience of and cost discounts through alternate delivery systems where choice is somewhat limited. However, other polls indicate that physicians maintain the respect of individual patients as individual personal physicians.

Further, we are on record as supporting a pluralistic system which allows innovative alternatives to exist. My admonition is to keep the decision making process as to whether or not one participates in a particular delivery system at the level of the patient and the physician. All models have their advantages and their disadvantages. The physician's responsibility is to educate himself regarding these variations. The organizations are encumbered to gather and promulgate this information in a readily accessible and understandable format.

The equation that must be balanced to accomplish a satisfactory component of this pluralistic system must include parity between quality, availability and cost of medical care. Peer input and peer review for equality is paramount, and evaluation of the local capability when considering high technology is essential. The economy of bringing these together in consideration of the local need acknowledges the place of cost in the equation.

Physicians who believe that we have developed the best medical care delivery system in the world by recognizing the needs and requests of our patients have the responsibility to resist being a captive of any payer purely for economic reasons when they perceive that a given system has a potential to result in loss of quality and availability of care for those patients. Low utilization and low risk groups will always exist concurrently with high risk patients and high risk groups, and many individuals will eventually find themselves in the latter. Therefore, cost shifting is detrimental to the balance of the entire system and shared risk is more characteristic of our medical care delivery system.

Finally, as we strive to maintain our level of medical care of the people, physicians must accept responsibility to devote a portion of their time to assist in the development of the future. By virtue of their medical education and experience in one-on-one patient care, they have a unique understanding that only those with this exposure can bring to the development of equitable positions.

We have three strata to work within, each with its own degree of difficulty and interactive requirements needing the above mentioned talents. The first is the insured or self-payer group, closely followed by those who are covered by governmental entitlement programs. These present the unique challenge of balancing what is available for continuing access to quality care. The third strata is the unfortunate band of so-called medically indigent, who do not quality for entitlement but are not capable of achieving other coverage. This most difficult range probably is our greatest challenge.

Therefore, in summary, as Abraham Lincoln referred to a government the people needed, I submit that the challenge of the prologue for us is to work for the medical care that people need. ◀

Robert P. Johnson, M.D.

Robert P. Johnson, M.D.
President

Obituaries

***Almassy, Arpad,** Worth, died September 26, 1983 at the age of 69. Dr. Almassy was a 1940 graduate of *Institutul de Medicina si Farmacia, Cluj,* Romania.

***Anslinger, Cyril,** Mt. Vernon, died December 17, 1983 at the age of 74. Dr. Anslinger was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

***Berger, Joseph P.,** Wells, Maine, died January 13, 1984 at the age of 60. Dr. Berger was a 1948 graduate of Northwestern University Medical School, Chicago.

Borges, Jane A., Chicago, died January 12, 1984 at the age of 63.

Dempsey, Raymond J., Joliet, died January 13, 1984 at the age of 60. He was a 1948 graduate of the University of Maryland School of Medicine, Baltimore.

****Fowler, Frank H.,** St. Petersburg, Florida, died January 28, 1984 at the age of 77. Dr. Fowler was a 1932 graduate of Northwestern University Medical School, Chicago.

****Gillette, Homer,** Centralia, died January 20, 1984 at the age of 95. Dr. Gillette was a 1910 graduate of Barnes Medical College, St. Louis, Missouri.

***Greaves, Donald,** Evanston, died January 9, 1984 at the age of 59. Dr. Greaves was a 1949 graduate of Washington University School of Medicine, St. Louis, Missouri.

***Michel, Moises G.,** St. Anne, died August 19, 1983 at the age of 65. Dr. Michel was a 1949 graduate of *Facultad de Medicina de la Universidad Nacional Auromoma de Mexico,* Mexico.

****Morrow, John C. W.,** Washington, Iowa, died January 25 1984 at the age of 96. Dr. Morrow was a 1921 graduate of Rush Medical College, Chicago.

****Reedy, Walter J.,** Ft. Lauderdale, Florida, died January 17, 1984 at the age of 74. Dr. Reedy was a 1933 graduate of Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania.

Rottschafer, Henry W., River Forest, died December 6, 1983 at the age of 77.

Samborski, Francis, Bloomington, died December 27, 1983 at the age of 82.

Sawyer, Tom M., Wilmette, died December 14, 1983 at the age of 58.

**Indicates ISMS Member*
***Indicates member of Fifty Year Club*

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PRDCARDIA® (nifedipine) **CAPSULES** For Dral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PRDCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management ot chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation ot sustained effectiveness and evaluation of long-term satety in those patients are incomplete.

Controlled studies in small numbers ot patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available intormation is not sufficient to predict with confidence the effects ot concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CDNTRAINDICATIONS: Known hypersensitivity reaction fo PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PRDCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism ot this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation ot PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended tor patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dystunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects ot increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration ot PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study ot over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment ot fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIDNS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose ot PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction ot PRDCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial intarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months ot nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HDW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nitedipine. PROCARDIA CAPSULES are supplied in bottles ot 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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(NIFEDIPINE) *Capsules 10 mg*

Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

The Town/Gown Dichotomy

This month's issue of the *Journal* includes an article entitled "The Origin of Medical Isolationism in America." The thrust of this paper is to point out the alleged lack of interaction and cooperation between full time academic physicians and those in full time private practice. The author further suggests that this somehow is a responsibility or fault of the full time academic physician. Several quotes from Osler's writings as well as other leaders at Johns Hopkins of that era tend to support these allegations.

It would seem just as reasonable to look at this apparent problem from the other side. Perhaps it is the full time private practitioner who looks down on the academician as a less than first class citizen. In the same speech of Osler's for which excerpts are used as illustrations in the paper in question, Osler also said: "Perhaps no sin so easily besets us as the sense of self satisfied superiority to others. It cannot always be called pride, that master sin, but more often it is an attitude of mind which either leads to bigotry and prejudice or to such a vaunting conceit in the truth of one's own beliefs and positions, that there is no room for tolerance of ways and thoughts which are not as ours are."

It would seem reasonable that such a "sin" could as easily be committed by the private practitioner as by the academician.

More important, however, is the fact that in today's society there are many institutions in which full time academic physicians work side by side with their fellows in full time private practice. The very economic facts of life that make it necessary for the so-called full time individual to devote a large portion of time to the practice of medicine, tend to cloud the obvious line of distinction between the two groups that once was present. Similarly, the private practitioner is becoming more and more involved in academic pursuits. One need only to look at the large number of newer community based medical schools to find a sense of camaraderie and cooperation that is very well developed. This is not to say that there are not individuals who commit Osler's sin of "a sense of self-satisfied superiority to others," but it takes only a moment to realize that it is committed as often by members of one as of the other group.

Dr. Graner's suggestion that the medical society might be a good common meeting ground is an excellent one. Fortunately, this has been going on more and more in an increasing number of communities. One only need look to the leadership of many medical societies to find full time physicians actively involved. The closest example is our own Illinois State Medical Society, whose president, Dr. Robert P. Johnson, is a full time professor at Southern Illinois University School of Medicine. Other examples abound.

Hopefully, this paper will stimulate interest in the subject of cooperation between academicians and private practitioners. Thoughts by "academicians" that they know more than the "LMD" should be banished forever, as should thoughts by the "private practitioners" that the academicians are lost in their ivory tower and unable to relate to the real world of medicine.

I hope that this article will stimulate some letters to the editor relating experiences concerning town and gown problems, and more importantly, solutions to town and gown problems. ◀

J. W. Roddick, Jr., M.D.
Chairman
IMJ Editorial Board

ABSTRACTS OF ACTIONS

January 21, 1984

O'Hare Marriott Hotel
Chicago, Illinois

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

ELECTION OF TRUSTEE

Due to the press of duties as an AMA Trustee, Dr. John J. Ring, First District Trustee, submitted a letter of resignation. The Board accepted the letter with regret. The First District position was then declared vacant and the Board elected the First District Caucus of Delegates' recommendation, Dr. David Littman, Highland Park, to succeed Dr. Ring, and to serve until the next election at the House of Delegates.

1984 BUDGET

The Board of Trustees approved a 1984 ISMS budget, reflecting revenue of $3,905,304, expenses of $3,843,963 and contributions to surplus of $61,341.

ILLINOIS HOSPITAL COST CONTAINMENT (S.B. 495)

The introduction of Senate Bill 495 last year touched off a debate within Illinois over how to control the rising cost of medical care. After reviewing an analysis of Senate Bill 495 and examining legislative alternatives, the Board directed that the Ad Hoc Committee on S.B. 495 continue to study the issues and report to the Executive Committee. The Board further empowered the Executive Committee to take whatever action is necessary.

UCR VERSUS INDEMNITY

At its September 24, 1983, meeting, the Board directed that the Illinois Delegation to the AMA recognize existing ISMS policy on UCR and attempt to delay any action by the AMA until the June, 1984 meeting, in order to allow full discussion by the ISMS House of Delegates.

In review and response to this, the Board approved a resolution entitled "Physician Reimbursement (UCR)" which resolves that: (1) In order to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician and his/her patients, ISMS supports the individual physician's right to choose which method of economic reimbursement for care best suits the needs of that physician and his/her patients; (2) Where appropriate, ISMS supports the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays; and (3) To the extent practicable, ISMS should strive to assist physicians in understanding alternative reimbursement systems.

(Continued on page 210)

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

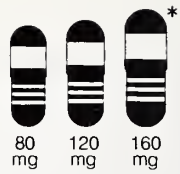
The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Just once each day for initial therapy in hypertension.

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Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end-diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is unclear.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the prial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. Further, there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing dose levels 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 7 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., ASSOCIATE PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was prepared by James Studlo, M.D., department of radiology, Loyola University Medical Center, Maywood.



Figure 1A

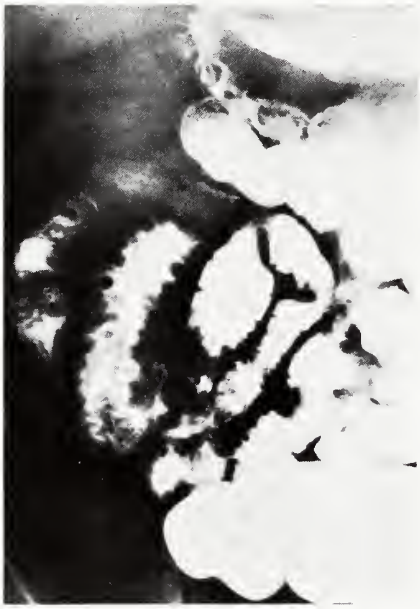


Figure 1B

Close up of distal ileum during barium small bowel series. (A) RLQ at one hour. (B) Same bowel segments at 1½ hours.

This 57 year old woman was hospitalized because of an eight month history of episodic cramping, abdominal pain and diarrhea. Recently she experienced episodes of wheezing. A barium small bowel study was obtained.

Your diagnosis?

(A) Crohn's disease
(B) Small bowel carcinomatosis
(C) Peritoneal mesothelioma
(D) Carcinoid tumor
(E) Small bowel lymphoma

(Continued on page 214)



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA** (PROPRANOLOL HCl) *LONG ACTING CAPSULES*

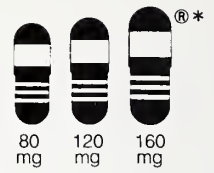


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JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
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The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

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Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
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CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

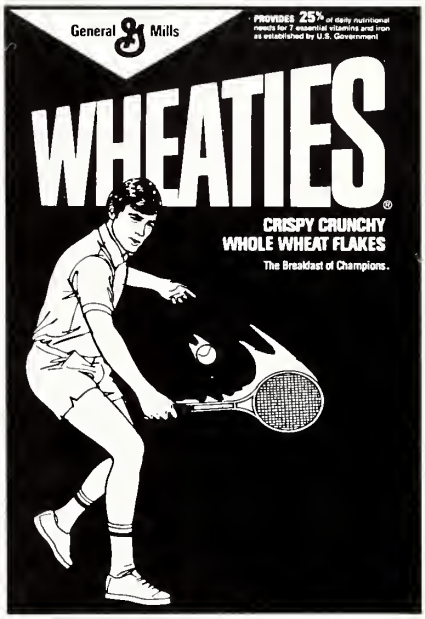
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Ode to Secret Message Rings



Dear Editor:

This morning I read a cereal box.

You know that I am an avid and voracious reader. The written word unread is to me as a pretty girl unkissed would be to younger men. This time of the year represents the nadir for readers such as myself—after the Christmas catalogs and before the spring garden and seed catalogs—a dearth of reading materials. Even medical journals and other reports missent and the newspapers and magazines of other folk had all been read.

Therefore, with nothing else at hand, I turned my attention at breakfast this morning to the cereal box. Copy has changed in the several years, or perhaps decades, since I last read a cereal box. Time was when they contained short but poignant epics of physical prowess, or directions for building a kite, or a coupon to fill out for a decoding secret message ring. Alas, those days are gone. Now there is a long list of ingredients. I suddenly had the realization that, if I were to be a knowledgeable consumer of cereals, I would have to understand and know what all of those ingredients were and what they meant. Oh, I longed for the days when Wheaties® meant Wheaties® and clearly whoever ate that breakfast of champions would ultimately be one.

While silently singing this lament, the needle of my mind skipped over a groove or two and came to rest on something I had read—perhaps in the *Wall Street Journal*—regarding the impending physician glut. The author cheered the fact that there would be more physicians because this would surely lower the cost of health care. He further cited as a happy event the fact that many of these physicians would be from schools not accredited by many United States licensing jurisdictions and thought it was a shame that barriers existed to prevent products of unaccredited schools from becoming doctors.

It seems clear to me that the present mood perhaps of the population at large or of the regulating bodies is one of "Let the Buyer Beware"—or perhaps "Be Wary."

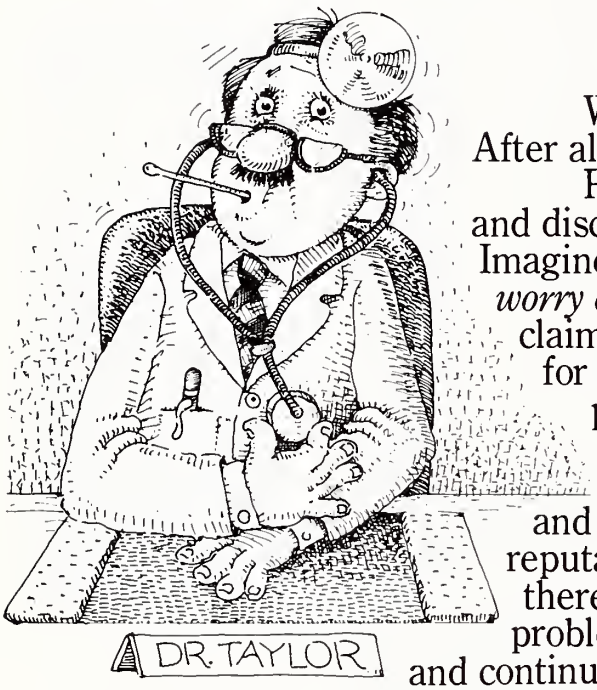
It gives me a chill to think ahead to the day when old Doc Frank is replaced by a younger physician and we are required as consumers to read his qualifications, probably posted on his office door. Looking at the courses taken and the number of years of clinical experience and where, the patient should then judge whether young doc is qualified to care for his or her particular problem or family member. Now that may take a fair amount of patient education.

It makes one yearn toward the validity of the brand name, in this case that a title of physician/doctor means that someone else who knows how to judge has made the determination that the quality is there and that the physician is well trained and able.

God knows they won't want to have to read the ingredients that go to make up a doctor. I never should have read that cereal box. ◀

Ys. Truly
E. Goodwins

Your practice very best



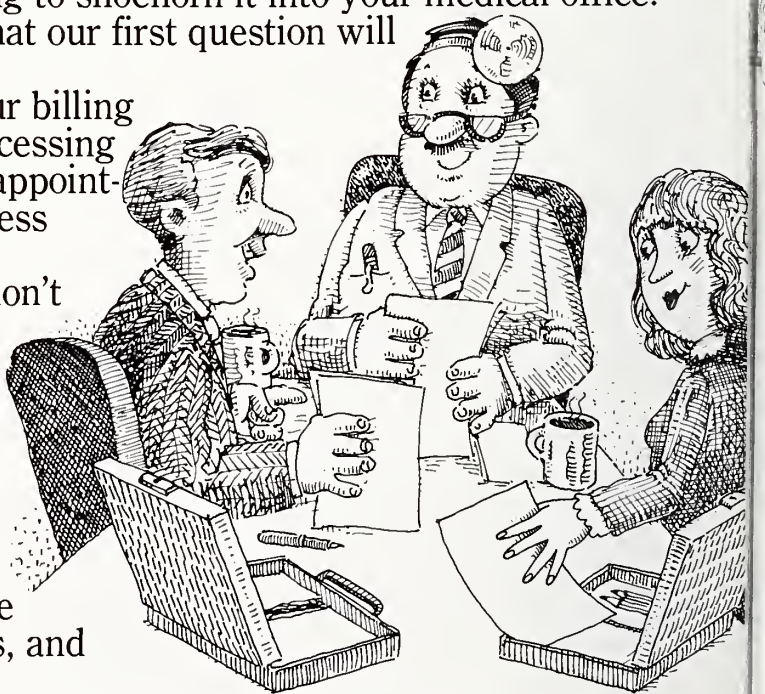
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Phone or write Management Systems of Wausau and discover how smoothly your practice can run. Imagine your bills going out on time *without any worry or bother on your part at all.* Imagine insurance claims processed without problems, recall notices for follow-up care issued automatically, lists of patients and surgeries provided on demand.

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DIAGNOSES Unlike typical computer management companies, we never start by presenting a service and trying to shoehorn it into your medical office. Actually, we offer so many services that our first question will be: "What do you really need?"

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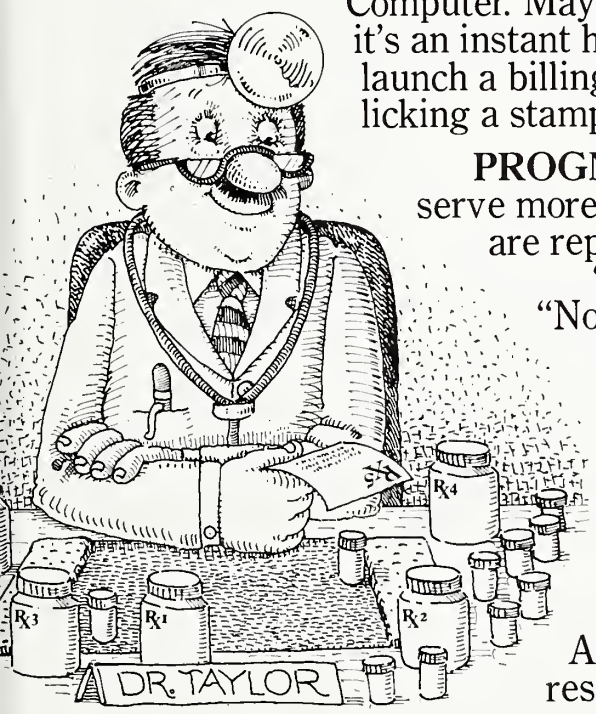


CONSULTATIONS In plain English, not computer or management jargon, we'll explain how to strengthen your financial control. For example, we can help you design more effective statements, collection notices, and routing slips.

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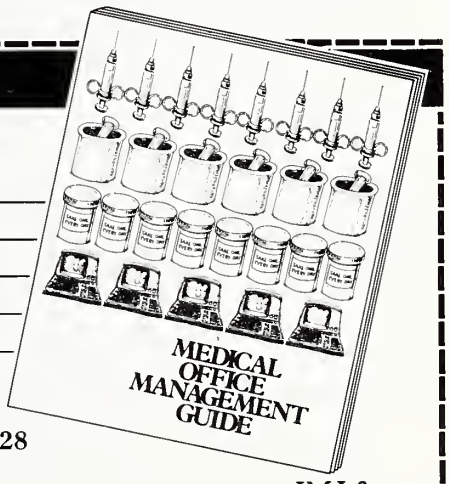
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DES PLAINES, ILLINOIS 60018

March, 1984

Dear Physician:

As the Carrier for the Medicare Part B Program in Illinois for the past five years, EDS Federal Corporation has sincerely appreciated the opportunity to serve you.

Your cooperation as well as that of the Illinois State Medical Society's officers, trustees and executive staff has greatly assisted us in providing you with a smooth-running Medicare Part B Program.

We are pleased to report that the current performance of EDS Federal ranks among the best of all Medicare Carriers in the United States. For some time now, the quality and timeliness of claims processing in Illinois has been the best the program has experienced since its inception in July, 1966. During January, 1984, EDS Federal processed a record 709,462 Medicare Part B claims for Illinois physicians and beneficiaries. Of this number, approximately 86 percent were processed in 15 days or less. Additionally, for the past two and one-half years, our claims inventory at the end of each month has been less than one week's claim receipts.

Although our contract for administration of the Illinois Part B Program will end on April 1, 1984, the timely and accurate processing of your Medicare claims continues to be of primary importance. The major efforts of our staff are directed toward finalizing all claims and correspondence received prior to mid-March, when our claims and correspondence receipts will be turned over to the new carrier. We are committed to reduce pending workloads to the lowest possible levels which will not encumber the new carrier.

For many months, we have been working closely with officials of the Health Care Financing Administration, Region V, and the new contractor to accomplish an efficient and orderly transition.

Thank you for your interest and cooperation over the past five years in our mutual responsibility to serve the Illinois Medicare beneficiaries.

Sincerely,

EDS Federal Corporation
Illinois Medicare Part B Carrier

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



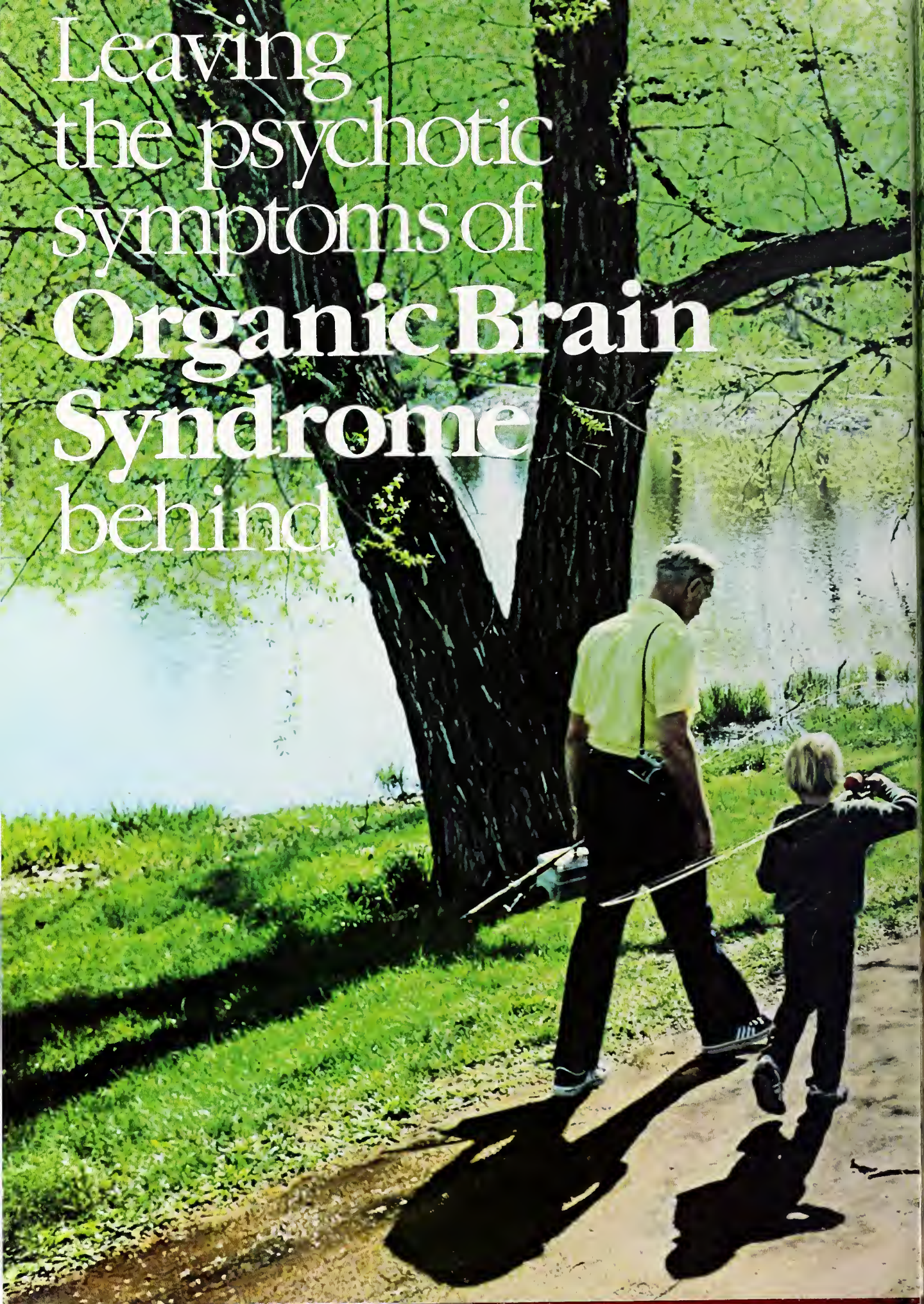
This is a fifty-eight year old man with a history of a myocardial infarction seven years ago. Last month, he came to the emergency service because of severe chest pain. The chest pain was retrosternal and did not radiate. It started after he shovelled snow off his driveway and was relieved by sublingual nitroglycerin in the emergency room. No further chest pain occurred. Subsequently the patient had an abnormal treadmill exercise electrocardiogram. A coronary angiogram was recommended. Further questioning about the myocardial infarction that occurred seven years ago yields the fact that the infarction was silent. His physician discovered the infarction on a routine ECG. There was no change from that ECG to this one taken prior to coronary angiography. His physical examination is normal with a blood pressure of 138/88mmHg.

Questions:

1. **The twelve lead ECG shows:**
 a. An old inferior wall myocardial infarction.
 b. An old true posterior wall myocardial infarction.
 c. Right ventricular hypertrophy.
 d. Left ventricular hypertrophy.
 e. Pre-excitation or Wolff- Parkinson-White syndrome.

2. **Reasonable considerations for treatment in this patient could include:**
 a. Sublingual nitroglycerin.
 b. Beta blocker drugs such as propranolol.
 c. Calcium channel blocking drugs such as nifedipine.
 d. Aortacoronary bypass surgery or coronary angioplasty.
 e. All of the above.

(Continued on page 165)


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[1,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

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at the forefront of psychopharmacology

Navane®
(thiothixene) (thiothixene HCl)

References: 1. Util TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16. 1972. 2. Katz MM, Util TM. Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM: Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml

Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.

Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels, the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis, the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

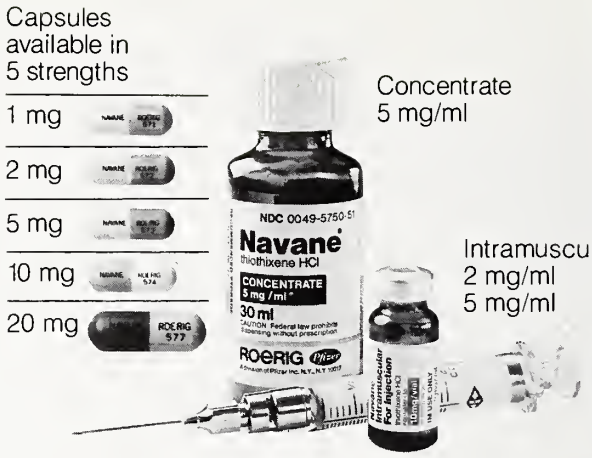
CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

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EKG

(Continued from page 161)

Answers: 1. E 2. E

The ECG shows sinus rhythm at 75 beats per minute and a PR interval of 0.12 seconds. Note how the P wave seems to run into the Q wave in leads II, III, and AVF as well as the R wave in leads AVL and V_1 to V_4. In these leads, this initial portion of the QRS is really a delta wave. (See arrows in leads II and V_4). The presence of a shortened PR interval and a delta wave suggest the diagnosis of Wolff-Parkinson-White syndrome. The QRS duration is not abnormally prolonged here at 0.10 seconds. The size of the delta wave and the degree of QRS distortion are related to anatomic location of the accessory pathway or the extra connection between the atria and ventricles. Thus the width of the QRS is related to anatomic location of the accessory pathway, intra atrial conduction time, and the conduction velocity of the accessory pathway and the atrioventricular node His-Purkinje system. A sinus impulse could then conduct mostly or only slightly down the accessory pathway. Since the QRS represents a fusion of impulses conducted down the accessory pathway and the His-Purkinje system, the resulting QRS will be widened to a variable degree in proportion to the contribution to ventricular depolarization made by each of these two pathways. A negative delta wave in leads II, III, and AVF and positive delta waves in leads V_1 to V_4 suggests the accessory pathway is located in the left posterior ventricle. Although most patients with the Wolff-Parkinson-White syndrome have a benign prognosis in the absence of tachycardias, misdiagnosis of their electrocardiogram can occur. In this patient, the delta waves create the false diagnosis of an inferior and true posterior myocardial infarction. Misdiagnoses of right or left ventricular hypertrophy are also possible. The Wolff-Parkinson-White syndrome can also cause false positive exercise electrocardiograms. Therefore, the ECG in this patient did not relate to his coronary artery disease at all. The coronary and left ventricular angiograms were normal except for an 80% obstruction in the left anterior descending artery. No evidence for an old myocardial infarction was seen. The diagnosis of myocardial infarction on the ECG was a misdiagnosis caused by the Wolff-Parkinson-White syndrome. All of the answers in questions 2 are treatment possibilities. Our patient was managed successfully with propranolol and nitrates.

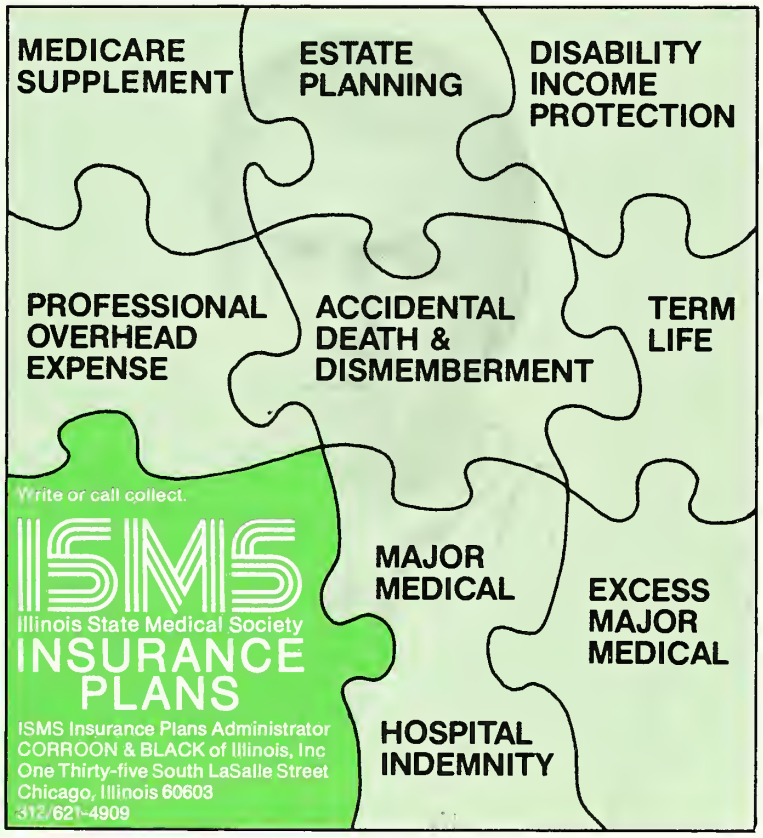
For further reading see "The Preexcitation Syndrome" by J. J. Gallagher et al, *Progress in Cardiovascular Diseases* 20:285-327, 1978.◀

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PITTSFIELD:
Population 4,200; County: 19,500.
(Continued on page 206)

Convention Handbook

Annual Meeting '84

April 6-8
Chicago Marriott (Downtown)
540 N. Michigan Avenue
Chicago, Illinois

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Delegates and Alternate Delegates to the Illinois State Medical Society
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Clark	Members: 6-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Steven Macke Cork Medical Center, Marshall 62441
Clay	Members: 7-Dist. 7	Alva P. Naney, Jr. 433 E. 7th St., Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
Clinton	Members: 15-Dist. 7	Howard Watson PO Box 99 Jamestown Rd. Breese 62230	Jonathan Osborn PO Box 99, Jamestown Rd., Breese 62230

County	*Members*	*President*	*Secretary*
Coles-Cumberland	Members: 67-Dist. 8	Gaylin D. Lack PO Box 218, Charleston 61920	Donald E. Binz, III 1810 Charleston, Mattoon 61938
Cook	Members: 9834-Dist. 3 Fred Schwartz, Exec. Dir. 515 N. Dearborn St. Chicago, IL 60610	Harry A. Springer 800 W. Austin, Evanston 60202	Richard H. Blankshain 715 Lake St., Oak Park 60301
Crawford	Members: 14-Dist. 8	Michael Elliott 1002 N. Allen, Robinson 62454	W.B. Schmidt Schmidt Clinic, Robinson 62454
DeKalb	Members: 60-Dist. 12	William K. Lee 232 S. Second, DeKalb 60115	John D. Wassner 954 W. State, Sycamore 60178
DeWitt	Members: 9-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas	Members: 9-Dist. 8	Humberto Mondul 111 W. South Central, Tuscola 61953	Grant A. Jones 318 S. Ash, Arthur 61911
DuPage	Members: 753-Dist. 11 Lillian Widmer, Ex. Admin. 800 Roosevelt Road Building B-Suite 300 Glen Ellyn 60137	Garth D. Smith 550 N. Monroe, Hinsdale 60521	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar	Members: 16-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham	Members: 19-Dist. 7	Herbert F. Webb Marshall Clinic, Effingham 62401	Ruben Boyajian 606 W. Kentucky, Effingham 62401
Fayette	Members: 12-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Alan D. Hoffman 725 W. Jackson, Vandalia 62471
Ford	Members: 17-Dist. 2	Robert Arthur Doctors Park, Gibson City 60936	David J. Hagan 214 N. Sangamon, Gibson City 60936
Franklin	Members: 24-Dist. 9	Yihnan Chiou 502 W. St. Louis St., Frankfort 62896	Bob G. Thompson 309 W. St. Louis St., Frankfort 62896
Fulton	Members: 38-Dist. 4	John Day 175 S. Main, Canton 61520	Hassan Alsheik 175 S. Main, Canton 61520
Gallatin	Members: 2-Dist. 9		John E. Doyle Ridgway 62979

County	*Members*	*President*	*Secretary*
Greene	Members: 6-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
Hancock	Members: 9-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
Henderson	Members: 1-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	Silvino Lindo, Jr. Biggsville 61418
Henry-Stark	Members: 33-Dist. 4	Luis Jose Garcia Kewanee Public Hosp., Kewanee 61443	Richard M. Terry 420 S. Chestnut, Kewanee 61443
Iroquois	Members: 20-Dist. 2	Philip F. Zumwalt PO Box 336, Sheldon 60966	A.T. DeVas Gunawardhane Central Comm. Hosp., 5th Ave., Clifton 60972
Jackson	Members: 138-Dist. 9	Punnoose Pachikara 106 S. 14th St., Murphysboro 62966	Brain G. McElheny 404 W. Main, Carbondale 62901
Jasper	Members: 2-Dist. 8	Juan Jose Serra 507 W. Washington, Newton 62448	Monico Low 609 S. Van Buren, Newton 62448
Jefferson-Hamilton	Members: 42-Dist. 9	Manoj H. Desai #1 Doctors Park Rd., Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
Jersey-Calhoun	Members: 10-Dist. 6	Kurella T. Sarma Maple Summit Rd., Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
Jo Daviess	Members: 9-Dist. 12	David Hockman 219 Summit St., Galena 61036	Francis B. Waites 219 Summit St., Galena 61036
Kane	Members: 326-Dist. 1 H. Michael Wild, Ex. Dir. 355 First St. Batavia 60510	Nasir J. Ahmad 296 W. Spring St., South Elgin 60177	Thomas R. Huberty 1240 N. Highland, Suite 22, Aurora 60506
Kankakee	Members: 114-Dist. 2	Randall L. Mann 401 N. Wall, Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
Kendall	Members: 8-Dist. 2	John P. Cullinan Main & VanBuren, Oswego 60543	Joseph Lee Daw Main & VanBuren, Oswego 60543

County	*Members*	*President*	*Secretary*
Knox	Members: 86-Dist. 4 Mrs. Jane Gau, Exec. Sec. Galesburg Cottage Hospital 695 N. Kellogg Galesburg 61401	Irene S. Caruso 612 Bondi Bldg., Galesburg 61401	Michael S. Sidell 695 N. Kellogg, Galesburg 61401
Lake	Members: 444-Dist. 1 Jane R. Stein, Exec. Dir. 1117 S. Milwaukee Forum One—Suite 13 Libertyville 60048	Edwin C. Salter 800 N. Westmoreland, Lake Forest 60045	Robert C. Munson 444 N. Prospect, Mundelein 60060
LaSalle	Members: 106-Dist. 2	Caner Celeboglu 104 6th St., Streator 61364	Allan L. Goslin 712 N. Bloomington, Streator 61364
Lawrence	Members: 11-Dist. 8 Ruth E. Gariepy, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Alexander Po RR 4, Lawrenceville 62439	Francisco E. Martin 542 N. Main, Bridgeport 62417
Lee	Members: 26-Dist. 12	Robert J. Piha 101 W. Mason, Polo 61064	Tiam H. Lie Rt. 5, Castellan, Dixon 61021
Livingston	Members: 31-Dist. 2	Homer C. Parkhill 202 N. Main, Pontiac 61764	Karl T. Deterding 612 E. Water, #109, Pontiac 61764
Logan	Members: 27-Dist. 5	Steven D. Kottemann 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
Macon	Members: 176-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	H. Gale Zacheis 301 Hay St., Decatur 62526	Robert D. Miller 1210 S. Jasper, Decatur 62521
Macoupin	Members: 19-Dist. 6	Padmavathi Talcherkar 75 Michael Steven Plaza, Carlinville 62626	Robert England 935 Morgan, Carlinville 62626
Madison	Members: 226-Dist. 6	Sadiq Mohyuddin 1308 W. Delmar, Godfrey 62035	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion	Members: 48-Dist. 7	Secundino E. Rubio Box 109, Salem 62881	W. P. Plassman 630 Short St., Centralia 62801

County	*Members*	*President*	*Secretary*
Marshall-Putnam	Members: 4-Dist. 2	E.R. Resurreccion, Jr. 14 E. Park Rd., Henry 61537	Joe W. Cannon 202 South Main, Lacon 61540
Mason	Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
Massac	Members: 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo Massac Memorial Hosp. Addition, Metropolis 62960
McDonough	Members: 33-Dist. 4	Don H. Dexter 505 E. Grant, Macomb 61455	Richard C. Watson 525 E. Grant, Macomb 61455
McHenry	Members: 86-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Honeid N. Eaxamusa 460 Coventry Crystal Lake 60014	Basudeb Saha 4318 West Crystal Lake Road, McHenry 60050
McLean	Members: 138-Dist. 5 Madge Williams, Exec. Sec. 1236 E. Empire Bloomington 61701	John L. Wright 2416 E. Washington St., Bloomington 61701	Jerry N. Ringer 1008 N. Main St., Bloomington 61701
Mercer	Members: 5-Dist. 4	Monty P. McClellan 309 N.W. 2nd St., Aledo 61231	Dennis D. Palmer 409 N.W. Fourth, Aledo 61231
Monroe	Members: 10-Dist. 10	Chung H. Khan 112 E. Fourth St., Waterloo 62298	Edilberto F. Maglasang 109 W. Legion, Columbia, 62236
Montgomery	Members: 17-Dist. 5	Dennis Ross Billiter Med. Arts. Bldg., 1235 E. Union Litchfield 62056	Roger Wujek Medical Arts Building 1225 E. Union, Litchfield 62056
Morgan-Scott	Members: 46-Dist. 6	James E. Hinchen 1515 W. Walnut, Jacksonville 62650	John H. McMillan 839 Grove, Jacksonville 62650
Moultrie	Members: 5-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951
Ogle	Members: 18-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron Road, Rochelle 61068

County	*Members*	*President*	*Secretary*
Peoria	Members: 453-Dist. 4 M. John Hanni, Jr., Ex. V.P. 427 1st National Bank Bldg. Peoria 61602	Chester Danehower, Jr. 5401 N. Knoxville, Peoria 61614	Thomas G. Cassidy 515 N.E. Glen Oak, Peoria 61603
Perry	Members: 14-Dist. 10	Raghuveer M. Kudva, PO Box 425, DuQuoin 62832	John G. Fozard 206 N. Main, Pinckneyville 62274
Piatt	Members: 5-Dist. 7	George Green 1111 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike	Members: 9-Dist. 6	Shehnaz Ansari 623 W. Washington, Pittsfield 62363	Carlos B. Lara 203 N. Madison, PO Box 328, Pittsfield 62363
Pulaski	Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
Randolph	Members: 23-Dist. 10	Allan L. Liefer 415 W. S. Fourth, Red Bud 62278	J. M. Whittenberg 1650 State St., Chester 62233
Richland	Members: 25-Dist. 8	Richard O. Peach Richland Mem. Hosp., Olney 62450	Chandri Varadachari Richland Memorial Hosp., Olney 62450
Rock Island	Members: 207-Dist. 4 James A. Koch, Ex. Sec. 608 Kahl Bldg. 326 W. Third St. Davenport, Iowa 52801	Earl M. Stockdale 2701-17th St., Rock Island 61201	James A. Bull 1240-10th St., Silvis 61282
St. Clair	Members: 282-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main, Suite 3L Belleville 62223	Robert C. Wanless 6401 W. Main, Belleville 62223	Robert E. Schultz, Sr. 6401 W. Main, Belleville 62223
Saline-Pope-Hardin	Members: 28-Dist. 9	Charles Seten 203 N. Vine, Harrisburg 62946	Allen G. Gerberding Prof. Arts Bldg., U.S. Rte. 45 South, Harrisburg 62946
Sangamon	Members: 428-Dist. 5 L. R. Brosi, Ex. Dir. 522 E. Monroe, Room 203 Springfield 62701	Michael C. Snyder 326 N. 7th, Springfield 62701	Elvin G. Zook SIU School of Medicine, PO Box 3926, Springfield 62708
Schuyler	Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681

County	*Members*	*President*	*Secretary*
Shelby	Members: 9-Dist. 7	P. D. Gurujal Shelby Cty. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
Stephenson	Members: 58-Dist. 12	William C. Sharelis 1036 W. Stephenson, Freeport 61032	Richard L. Rice 750 Kiwanis Dr., Freeport 61032
Tazewell	Members: 71-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	John E. Lovell, PO Box 778, Pekin 61555	M.A. Sheikh PO Box 778, Pekin 61555
Union	Members: 12-Dist. 9	Jerry L. Goddard 517 N. Main, Anna 62906	Carroll O. Loomis Union County Hosp., Main St., Anna 62906
Vermilion	Members: 119-Dist. 8	Edward C. Farkas 600 Sager, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
Wabash	Members: 6-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
Warren	Members: 17-Dist. 4	Kenneth E. Ambrose 219 E. Euclid, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington	Members: 6-Dist. 10	Gary Goforth 113 W. St. Louis Nashville 62263	Ralph H. Kelley 113 W. St. Louis, Nashville 62263
Wayne	Members: 10-Dist. 9	John W. Royalty PO Box 66, Cisne 62823	Eugene B. Loftin 301 N.W. Eleventh St., Fairfield 62837
White	Members: 6-Dist. 9	Morris A. McCall R.R. 2, Box 132 B, Carmi 62821	Morris A. McCall R.R. 2, Box 132 B, Carmi 62821
Whiteside	Members: 55-Dist. 12	Thomas S. Vinje 101 E. Miller Rd., Sterling 61081	Kevin Roache 101 E. Miller Rd., Sterling 61081
Will-Grundy	Members: 265-Dist. 2 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Jon F. Nicosia 2000 Glenwood, Joliet 60435	Morton D. Barnett 301 N. Springfield, Joliet 60435
Williamson	Members: 40-Dist. 9	Timoteo Castro, Jr. 120 W. Walnut, Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918

County	Members	President	Secretary
Winnebago	Members: 421-Dist. 12 Robert Carlson Exec. Adm. 630 E. Jefferson Rockford 61107	Norm A. Hagman PO Box 6144, Rockford 61125	Jovenel Dubois 5670 E. State St., Rockford 61108
Woodford	Members: 6-Dist. 2	Victor V. Jay 601 N. Jefferson, Washburn 61570	James W. Riley 109 S. Major, Eureka 61530

No Organized County Society: Cass-Brown, Edwards, Johnson, Menard

Joint County Societies: Coles-Cumberland; Henry-Stark; Jefferson-Hamilton; Jersey-Calhoun; Marshall-Putnam; Morgan-Scott; Saline-Pope-Hardin; Will-Grundy.

ISMS Annual Meeting

Program Summary By Days

April 4-8, 1984—CHICAGO MARRIOTT HOTEL (DOWNTOWN)

WEDNESDAY, APRIL 4, 1984

2:00 p.m.	ISMIE Executive Committee Meeting
4:00 p.m.	Annual ISMIE Membership Meeting
5:00 p.m.	ISMIE Board of Governors Meeting

THURSDAY, APRIL 5, 1984

9:00 a.m.	ISMS Board of Trustees Meeting

FRIDAY, APRIL 6, 1984

7:30 a.m.	ISMS Board of Trustees Meeting
7:30 a.m.	Rules and Order of Business Meeting
8:00 a.m.	Registration
8:00 a.m.	CMS Caucus
8:30 a.m.	Meeting of Reference Committee Members
8:30 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:15 a.m.	IMPAC Annual Meeting
11:30 a.m.	District Meetings
11:30 a.m. 1:30 p.m.	Delegates' Buffet
1:30 p.m.	Reference Committees
7:00 p.m.	President's Night

SATURDAY, APRIL 7, 1984

7:30 a.m.	Public Affairs Breakfast
8:00 a.m.	Registration
8:30 a.m.	CMS Caucus
9:00 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:00 a.m.	Medical Student Section Meeting
11:00 a.m.	Resident Physicians Section Meeting
11:30 a.m.	Fifty Year Club Luncheon
1:00 p.m.	CMS Caucus (if necessary)
1:30 p.m.	Credentials Committee
2:00 p.m.	House of Delegates
4:45 p.m.	District 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12 Caucus

SUNDAY, APRIL 8, 1984

7:30 a.m.	ISMS Board of Trustees Meeting
8:00 a.m.	Registration
8:30 a.m.	Credentials Committee
9:00 a.m.	House of Delegates
	Board of Trustees Reorganization Meeting Immediately Following House Adjournment.

Agenda
1984 House of Delegates

Julian W. Buser, M.D., Speaker/Lawrence L. Hirsch, M.D., Vice-Speaker

First Session

9:30 a.m. ——— Friday, April 6, 1984 ——— Chicago Marriott (Downtown)
Grand Ballroom, Salon II, Seventh Floor

1. Call to order
 Julian W. Buser, M.D., *Speaker*
2. Invocation
3. Ratification of appointment of Committee on Rules and Order of Business
4. Report of Committee on Rules and Order of Business
5. Report of Credentials Committee
6. Approval of minutes of previous meeting
7. Memorial Service for members deceased since April, 1983, conducted by Jere Freidheim, M.D., *Secretary-Treasurer*
8. Introduction of special guests
9. Report of Chairman, Board of Trustees, Warren D. Tuttle, M.D.
10. Remarks of Speaker
11. Resolutions and supplementary reports
12. New business and announcements
 Delegates' Buffet—11:30a.m.-1:30p.m.
 Reference Committees—1:30 p.m.
13. Recess until 9:30a.m., Saturday, April 7, 1984

Second Session

9:30 a.m. ——— Saturday, April 7, 1984 ——— Chicago Marriott (Downtown)
Grand Ballroom, Salon II, Seventh Floor

1. Call to order by the Speaker
2. Report of Credentials Committee
3. Reports of special guests
 Mrs. Susanne F. Webb, president, Illinois State Medical Society Auxiliary
 Betty Kronemeyer, C.M.A., president, Illinois Society, American Association of Medical Assistants
4. Introduction of special guests
5. Presentation of educational awards
 Certificates of appreciation to continuing medical education examiners
 Edwin S. Hamilton Teaching Award
6. Presentation of AMA-ERF check to Illinois medical schools
7. Announcement of team physician awards
8. IMPAC report
 Cyril C. Wiggishoff, M.D., Chairman
9. Report of Executive Administrator
 Mr. Alexander R. Lerner
10. Introduction of AMA Delegates and Alternate Delegates
 Howard C. Burkhead, M.D., Chairman
11. President's Address
 Robert P. Johnson, M.D.
12. New business and announcements
13. Reports of reference committees
14. Recess until 2:00 p.m.
15. Call to order by the speaker
16. Reports of Reference Committees
 Amendments to Constitution and Bylaws
 Committee A-officers, administration, finances, budgets, medical-legal and governmental affairs
 Committee B-government health programs, including health care finance and economics
 Committee C-education, manpower and clinical medicine, scientific matters and medical services
 Committee D-standby
17. New business
18. Recess until 9:00a.m., Sunday, April 8, 1984

Third Session

9:00 a.m. ——— Sunday, April 8, 1984, ——— Chicago Marriott (Downtown)
Grand Ballroom, Salon II, Seventh Floor

1. Call to Order by the Speaker
2. Report of Credentials Committee
3. Induction of Robert C. Hamilton, M.D., President-Elect, into office of President by Robert P. Johnson, M.D.
4. Address of President Hamilton
5. Announcements and introduction of guests
6. Reports of Reference Committees
7. Elections
 Report of Nominating Committee
 a. President-Elect (Downstate)
 b. 1st Vice-President (Cook County)
 c. 2nd Vice-President (Downstate)
 d. Secretary-Treasurer
 e. Speaker of the House (Downstate)
 f. Vice-Speaker of the House (Cook County)
 g. Trustee Terms Expiring

District	*Terms Expiring*
First District	David B. Littman, M.D.
Third District	Morris T. Friedell, M.D.
Third District	Henrietta Herbolsheimer, M.D.
Third District	Arthur R. Peterson, M.D.
Third District	Clifton L. Reeder, M.D.
Sixth District	Robert R. Hartman, M.D.
Ninth District	Warren D. Tuttle, M.D.
Tenth District	Thomas P. Meirink, M.D.

 h. Delegates to AMA to take office January 1, 1985 and serve until December 31, 1986

 Terms Expiring

 David S. Fox, M.D., Chicago
 Morris T. Friedell, M.D., Chicago
 Henrietta Herbolsheimer, M.D., Chicago
 Lawrence L. Hirsch, M.D., Chicago
 Michael Nieder, M.D., Chicago
 Joseph R. O'Donnell, M.D., Glen Ellyn
 P. John Seward, M.D., Rockford
 George T. Wilkins Jr., M.D., Edwardsville
 Vacancy (Downstate)

 i. Election of delegate to AMA to take office immediately and serve until December 31, 1984, completing the unexpired term of John J. Ring, M.D.

 j. Alternate delegates to AMA to take office January 1, 1985 and serve until December 31, 1986

 Terms Expiring
 Andrew J. Brislen, M.D., Chicago
 Audley F. Connor, Jr., M.D., Chicago
 James R. DeBord, M.D., Peoria
 Alfred J. Kiessel, M.D., Decatur
 Clifton L. Reeder, M.D., Chicago
 Harry Springer, M.D., Evanston
 Joseph Perez, M.D., Rockford
 Richard Terek, Chicago

 k. Judicial Panel to take office April 6, 1984 and serve until April, 1989; nominated by ISMS President Arthur Fischer, Chicago
 l. Rules and Order of Business Committee to take office April, 1984 and serve until April, 1985
 Five (5) delegates nominated by the Speaker and Vice-Speaker of the House
8. Fixing of per capita dues for 1985
9. Selection of meeting place and time for next meeting
10. Unfinished business
11. New business
12. Adjournment, Sine Die

Illinois State Medical Society
Illinois State Medical Society Auxiliary
Benefit Raffle
for the
Educational and Scientific Foundation's
Medical Student Loan Fund

Drawing Held April 7, 1984
At ISMS Annual Meeting

1st Prize: Grandfather's Clock/2nd Prize: Portable VCR and Color Camera
3rd Prize: Ritz Carlton Chicago Weekend/4th Prize: Sony "Watchman" Portable TV
Other Prizes to be Announced

Ticket books mailed to all ISMS/ISMSA members

Winners need not be present
Contributions to the ISMS Educational and Scientific Foundation are normally tax deductible to the extent allowed by law.

Report to the House of Delegates

ISMS Delegation to the AMA

The American Medical Association Interim Meeting was held December 4-7, 1983 in Los Angeles. Illinois was represented by a full complement of 17 delegates or alternates on the floor at all times. In addition, we were joined by Dr. Ring and specialty society delegates from Illinois.

Several issues were addressed by the House and I wish to call your attention to some of them at this time.

Pertaining to standards of the Joint Commission on Accreditation of Hospitals, after lengthy debate on legal and patient care implications involved with this issue, the House adopted the following policy statements:

> That it be the policy of the American Medical Association that the hospital medical staff grant admitting privileges to appropriately-credentialed limited-license practitioners in accordance with state laws and in accordance with the criteria for standards of medical care established by each individual hospital medical staff.
>
> That it be the policy of the American Medical Association that hospital admitting privileges be granted in accordance with state law and in accordance with criteria for standards of medical care established by the individual hospital medical staff.

With respect to the insanity defense in criminal trials, the House adopted a report calling for a narrowing of the use of the insanity defense in criminal trials. The purpose of this new position is to decrease the time and costs involved in criminal trials and to provide greater opportunity for appropriate treatment of the mentally ill. Since both the American Bar Association and the American Psychiatric Association have adopted differing positions, the AMA will join in a collaborative effort with these groups to achieve a common position.

The House amended and then approved a report of the Council on Medical Services regarding physician reimbursement by means of indemnity vs. UCR. This report reflected study of the positive aspects of indemnity schedules. In amending the report, the House supported freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees, freedom for patients to select their source of care, and a fair market among alternative health care delivery and financing systems. While Illinois had no resolutions before the House, an item introduced as a late resolution by Dr. O'Donnell was enacted. This action supports the right of a physician to balance bill a patient for any care given regardless of method of payment, where permissible by law or contract agreement.

Your delegation met in caucus the day prior to the meeting and each day during the meeting. All reports and resolutions were reviewed and appropriate comment and testimony were developed for presentation to the reference committees.

In June, 1984, at the AMA Annual Meeting, Dr. Joseph Skom will be a candidate for re-election to the Council on Scientific Affairs. In addition, Dr. Ronald Davis will be a candidate for the new resident position on the AMA Board of Trustees. We congratulate Dr. Ring on his successful campaign in 1983 for AMA Trustee. Our good wishes, also, for Dr. Frank J. Jirka, Jr., as he completes his term as president of the AMA.

I am happy to report that the ISMS Delegation functions smoothly and effectively. We anticipate that we will be on the campaign trail for the 1984 Annual Meeting in support of candidates from Illinois. For this we will need the assistance of all members of ISMS. It is a privilege for each member of the Delegation to serve this House of Delegates and to represent the physicians of Illinois.

Howard C. Burkhead, M.D., *Chairman*
Morgan M. Meyer, M.D., *Secretary*

ISMS Delegation to the AMA

Delegation Chairman: Howard C. Burkhead; Secretary: Morgan Meyer

Delegates

To serve from Jan. 1, 1983 to Dec. 31, 1984

(Elected April 17, 1982)

David S. Fox, Chicago
Morris T. Friedell, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Chicago
Michael Nieder, Chicago*
Joseph R. O'Donnell, Glen Ellyn
P. John Seward, Rockford
George T. Wilkins, Edwardsville

To serve from Jan. 1, 1984 to Dec. 31, 1985

(Elected April 24, 1983)

Howard C. Burkhead, Evanston
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Morgan M. Meyer, Lombard
Joseph H. Skom, Chicago
Arthur Traugott, Urbana
Cyril C. Wiggishoff, Chicago
Vacancy (Down state)

Honorary Members

Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, New York
John J. Ring, Mundelein

Alternates

To serve from Jan. 1, 1983 to Dec. 31, 1984

(Elected April 17, 1982)

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
James DeBord, Peoria**
Alfred J. Kiessel, Decatur
Joseph Perez, Rockford
Clifton L. Reeder, Wilmette
Harry Springer, Chicago
Richard Terek, Chicago*

To serve from Jan. 1, 1984 to Dec. 31, 1985

(Elected April 24, 1983)

Randall T. Bellows, Chicago
Jere Freidheim, Chicago
Allan Goslin, Streator
Harold Jensen, Flossmoor
A. Beaumont Johnson, Elgin
Pedro A. Poma, Melrose Park
Warren D. Tuttle, Harrisburg
Ronald Welch, Belleville
Fred Z. White, Chillicothe

**Elected April 24, 1983 to seventeenth position*
***Elected April 24, 1983 to complete unexpired term beginning Jan. 1, 1984*

Notification of Annual IMPAC Meeting

The 1984 Annual Meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Friday, April 6, 1984, *immediately following the adjournment of the ISMS House of Delegates.*

11:15 a.m. (approx.)
7th Floor-Grand Ballroom
Salon 2
Chicago Marriott Hotel
Chicago, Illinois

All members of IMPAC are invited and encouraged to attend.

The 1984 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council:

Alfred Clementi, M.D., Arlington Heights
Louis E. Dondanville, M.D., Moline
Edwin Falloon, M.D., Palos Heights
Morris T. Friedell, M.D. Chicago
Don E. Hinderliter, M.D., Rochelle
John W. Ovitz, Jr., M.D., Sycamore
Albert W. Ray, Jr., M.D., Joliet
P. John Seward, M.D., Loves Park
Herbert Sohn, M.D., Chicago
A.E. Steer, M.D., Springfield

Committees of the House of Delegates

Committee on Rules and Order of Business

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (30 days prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

Committee on Credentials

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform other such duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

Tellers and Sargeants At Arms

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

Reference Committee on Amendments to Constitution and Bylaws

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws, matters relating to policy, and peer review concerns.

Reference Committee A

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances, budgets, medical-legal matters, and governmental affairs.

Reference Committee B

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including cost containment, health care financing, economics, and miscellaneous business.

Reference Committee C

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower, clinical medicine, scientific matters and medical services.

Resolutions
1984 Annual Meeting
ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 6 and, according to provisions of the bylaws, are printed in IMJ by title and subject. Final deadline for resolutions was March 6. At this writing it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

Number	Subject	Submitted by
1 (A-84)	Eligibility for Retired Member Status	Raymond E. Hoffmann, M.D., for the Winnebago County Medical Society
2 (A-84)	Board of Trustees Committee on Building and Capital Equipment	Warren D. Tuttle, M.D., for the Board of Trustees
3 (A-84)	Amendment to Chapter IX, Section 5 of the ISMS Bylaws	Warren D. Tuttle, M.D., for the Board of Trustees
4 (A-84)	Physician Reimbursement (UCR)	Warren D. Tuttle, M.D., for the Board of Trustees
5 (A-84)	Support for Voluntary Continuing Medical Education in Illinois	Warren D. Tuttle, M.D., for the Board of Trustees
6 (A-84)	Hospital Education Programs for Care and Treatment of Infants Born with Disabilities	Warren D. Tuttle, M.D., for the Board of Trustees
7 (A-84)	Policy Statement on "Autopsies"	Warren D. Tuttle, M.D., for the Board of Trustees
8 (A-84)	Policy Statement on "The Privacy of Physician Records"	Warren D. Tuttle, M.D., for the Board of Trustees
9 (A-84)	Alice Hamilton, M.D. Commemorative Stamp	Harry A. Springer, M.D., for the Chicago Medical Society
10 (A-84)	Enabling Action for PPO Promulgation	Lewis Trupin, M.D., Harlan Failor, M.D., and Robert Welke, M.D., for the Champaign County Medical Society
11 (A-84)	Legal Drinking Age—National Unification	Lewis Trupin, M.D., Harlan Failor, M.D., and Robert Welke, M.D., for the Champaign County Medical Society
12 (A-84)	American Cancer Society Proposed Cancer Patient Hotline Referral	Robert Wanless, M.D., for the St. Clair County Medical Society
13 (A-84)	Illinois Office of Education Proposal to Eliminate Mandatory 5th & 9th Grade Medical Examinations	Robert Wanless, M.D., for the St. Clair County Medical Society

YOU'RE INVITED

To a complimentary Public Affairs Breakfast on Saturday, April 7, 1984, 7:30 a.m., Chicago Marriott Hotel (Downtown)

Tickets for the breakfast will be available at convention registration during the ISMS Annual Meeting on a first come, first served basis.

For further information, please contact James Tierney at ISMS offices, 55 East Monroe, Suite 3510, Chicago 60603. Telephone (312) 782-1654.

Schedule of Associated Meetings

Wednesday, April 4, 1984 4:00 p.m.	Illinois State Medical Inter-Insurance Exchange Annual Meeting of Members The principle purpose of this meeting will be the election of members to the Exchange Board of Governors for the 1984-85 term. All members of the Exchange are urged to participate either by personal attendance or by timely execution of their proxy statement.
Friday, April 6, 1984 11:15 a.m.	Illinois State Medical Society Political Action Committee Annual Meeting
Friday, April 6, 1984 7:00 p.m.	President's Night
Saturday, April 7, 1984 7:30 a.m.	ISMS Public Affairs Breakfast Tickets available at ISMS registration desk
Saturday, April 7, 1984 11:00 a.m.	Medical Student Section Annual business meeting and election of officers
Saturday, April 7, 1984 11:00 a.m.	Resident Physicians Section Annual business meeting and election of officers

ISMS Auxiliary 56th Annual Meeting
Chicago Marriott Hotel

Thursday, April 5

Noon	Pin and Gavel Luncheon (Past Presidents Only)
Afternoon	Leisure Time
2:00 p.m.	Pre-Convention Board of Directors Meeting
7:00 p.m.	Board of Directors Dinner
Evening	Auxiliary Hospitality Suite

Friday, April 6

8:00 a.m.	House of Delegates Registration
9:00 a.m.	First House of Delegates Session Call to Order and Greetings Opening Ceremonies Reading of Rules Budget Reading and Approval President's Report to House of Delegates Keynote Speaker: Billie Brady, AMAA President-Elect County Presidents' Reports Election Instructions Nominating Committee Report
Noon	Reception for AMAA President-Elect and ISMSA Past Presidents
12:30 p.m.	President's Luncheon
2:00 p.m.	Guest Speaker: Margaret Dykinga, R.N., M.Ed. Management Consultant/Counselor, Contact, Inc.
3:30 p.m.	Presidents-Elect Meeting
4:00 p.m.	Legislative Chairmen Meeting
7:00 p.m.	ISMS President's Night—Robert P. Johnson, M.D., President
Late Evening	Auxiliary Hospitality Suite

Saturday, April 7

7:30 a.m.	ISMS Public Affairs Breakfast
9:00 a.m.	Second House of Delegates Session Elections Memorial Service Award Presentations
10:00 a.m.	Workshop: "Communicating Orally" John Moore, Assistant Professor of Communication Arts, Loyola University
11:00 a.m.	Workshop: "The Mysterious World of Membership" Betty Szewczyk, AMAA North Central Regional Vice President Workshop: "Pierre the Pelican—Health Projects Development" Mary McCormick and Penny Troy, Sangamon County Members
Noon	Installation Luncheon Annual Meeting Adjournment
Afternoon	ISMS/ISMSA Raffle to benefit Medical Student Loan Fund
2:00 p.m.	Board of Directors Photograph
2:15 p.m.	Post Convention Board of Directors Meeting
Afternoon	Leisure Time

CONVENTION '84

The 144th Annual Meeting
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540 N. Michigan
Chicago, Illinois
April 6-8, 1984

- ISMS House of Delegates
- President's Night
- Annual IMPAC Meeting
- Public Affairs Breakfast

Further information about convention may be obtained by contacting the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago Illinois, 60603; (1-312-782-1654).

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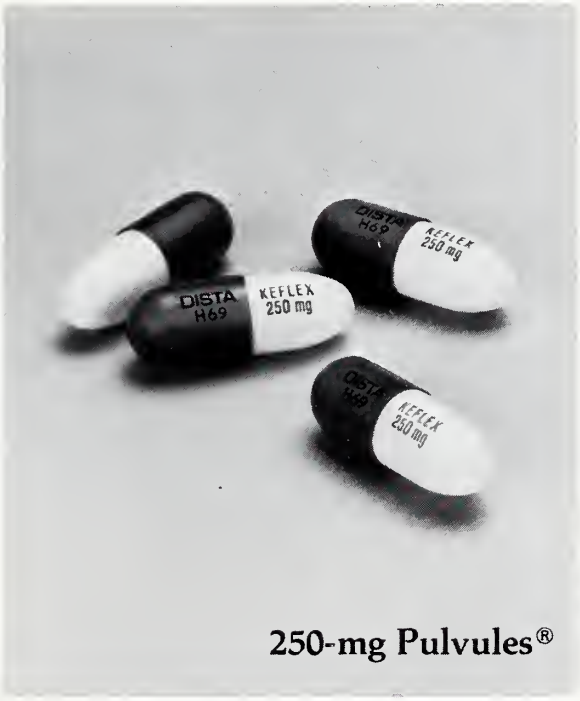
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**Additional NMR information on page 221*

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 165, No. 3
March 1984

Part One: Facial Surgery

Plastic Surgery Update

By Robert M. Swartz, M.D., and Robert E. Knode, M.D./Chicago

This review article describes techniques available in cosmetic and reconstructive surgery. The article is in two parts; the first covers cosmetic surgery of the face and the second, plastic and reconstructive surgery of the breasts, trunk and extremities.

This series will conclude in next month's issue of IMJ.

Physicians often recognize psychological symptoms which, in turn, lead to physical symptoms. In some cases, ills caused by the patient's thoughts derive from the patient's own self image. In the course of taking a history or working to diagnose a physical problem, physicians may be confronted with patients whose lives have proceeded under clouds of self pity or feelings of inferiority because of facial or anatomical characteristics.[1]

While some surgical techniques are life saving, others may improve the quality of life. Plastic surgery offers opportunities for better lives for many who view some aspect of their appearance as a hindrance to acceptance or success.

This two part article is an update on possibilities for reconstruction and techniques to enhance appearance through plastic surgery. It is presented so that physicians in all specialties will be better prepared to understand their patients' concerns and hopes for improvement. Part I discusses facial surgery. Part II, in the next issue of the *Journal,* will discuss cosmetic surgery for breasts, trunk and extremities.

Initial Evaluation

The most important step in facial rejuvenation is taken before the surgical procedure itself. The cosmetic surgeon must carefully evaluate each patient's motivation, stability and medical status. Good candidates for facial surgery have realistic hopes, well-integrated personalities and are in overall good health. Because of recent advances, many facial cosmetic surgery procedures can be performed on an outpatient basis. The surgeon will determine the best place for each procedure during consultation. Where there is concern about the patient's medical status or where the patient desires hospitalization for appropriate reasons, procedures may be performed in the hospital instead of the office or other outpatient setting.

The most common facial procedures include meloplasty, blepharoplasty, otoplasty, improvement of acne scarring or facial lines with collagen injection, dermabrasion, chemical face peeling, rhinoplasty, and mentoplasty.

Meloplasty

Meloplasty, the face lift operation, is a frequently performed "rejuvenation" procedure. At least 40,000 such operations are performed each year in the U.S. It consists of redraping the skin of the face through strategically placed incisions beginning in the temporal area, extending from behind the tragus and then posteriorly along the postauricular region and hairline of the posterior scalp. Extensive undermining of the facial skin in the subcutaneous plane can be performed through the incision to near the lateral orbital region, nasolabial fold, and submental area well down toward the clavicular area of the neck if necessary.[2] The extent of undermining depends largely upon the goals desired in alleviating facial sagging. The condition of the patient's tissues and the surgeon's ability to perform a relatively blood free dissection influence the chances for complications.

Two frequently performed adjuncts to the standard face lift include a coronal extension of the incision through the scalp, thus allowing full undermining of the

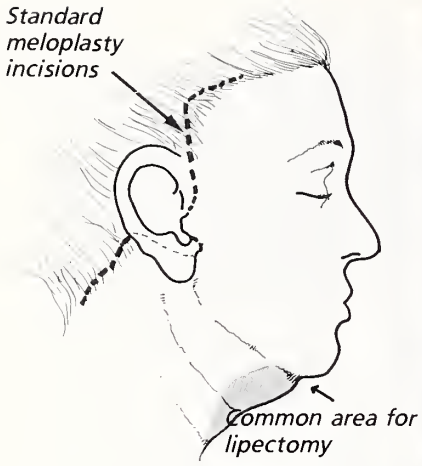


Figure 1
Meloplasty incision site and lipectomy site



Figure 2A (Before)



Figure 2B (After)
Figure 2 Meloplasty with lipectomy

forehead to the supraorbital rims,[3] and a transverse submental incision allowing more extensive dissection of the submental region. When using a coronal incision, the forehead muscles (frontalis procerus and curragator) can be partially divided in an effort to remove prominent frown lines. A more extensive defatting of the neck and lower face can be carried out through the submental incision and lax platysmal muscle bands can be repaired or excised. A surgical approach to the deeper apponeurotic layer of the facial tissues (SMAS) can be performed, tightening this layer with appropriate dissection and well placed sutures.[4] Many think that attention to this layer may prolong the lasting qualities of the facial surgery. It seems, however, that the most dramatic change in a cosmetic surgeon's ability to perform an adequate face lift relates to more aggressive defatting of the facial tissues, an approach which can change the facial appearance so dramatically that at times it actually improves the basic contour over and above that which existed in the patient's youth. (See Figures 1 and 2)

Blepharoplasty

Probably no other procedure in facial plastic surgery gives a more dramatic change in facial "freshness" than the blepharoplasty. More than 57,000 such operations are performed in the U.S. each year. The basic skin incision patterns include excision of a modified ellipse of skin from the upper eyelid followed by a strip resection of the obicularis oculi muscle. Such resection, if conservatively performed, causes no functional deficiency and greatly improves the surgeon's ability to obtain a good supratarsal fold.[5] Fat pad resection is also an integral part of the upper eyelid blepharoplasty, most prominently in the medial area of the upper eyelid.

The lower eyelid blepharoplasty is usually carried out through a lash margin incision which gives excellent exposure to the lateral, mid and medial lower eyelid fat pads

and allows the surgeon to construct a flap of skin and muscle. The greatest improvement in the lower eyelid appearance often comes from resection of these fatty deposits. A very narrow strip of skin is resected to avoid ectropion, the most dreaded complication of lower eyelid blepharoplasty. Several procedures allow tightening of the tarsal portion of the lower eyelid. These include the resection of a narrow segment of tarsal plate and various tightening techniques directed at the obicularis muscle to obtain a more competent lower eyelid structure and avoid ectropion while possibly allowing more aggressive skin resection.[6] Even with such adjunctive procedures, conservatism is vital.

Other approaches to the upper eyelid are also available. These include the so called "anchor blepharoplasty" in which a previously lacking tarsal fold is produced. Using multiple fine sutures, the lower edge of the divided obicularis oculi muscle is sutured to the levator apponeurosis at a suitable level. This approach is similar to the "westernization" procedure for the oriental eye and is carried out for the same purpose.[7]

Blepharoplasty is frequently performed in conjunction with the face lift operation and, using appropriate precautions, can be carried out safely on an outpatient basis in healthy patients. Usually a local anesthetic is given for both procedures together with a suitable sedative. Figures 3 and 4 show upper blepharoplasty and tarsal wedge resection blepharoplasty, before and after.

Otoplasty

Prominent ears are often the concern of young as well as older patients. A poorly formed anthelical fold is the most common deformity producing too-prominent ears. A reforming of the anthelical fold is the focus of otoplasty. In this as in other facial procedures, preoperative markings are essential. In otoplasty, the goal is projection of a correct placement for the anthelical fold.

The surgery is carried out through postauricular incisions with a properly placed modified elliptical skin excision followed by techniques to score and weaken the "spring" of the auricular cartilage. This is accomplished by dividing the anterior perichondrium to encourage posterior folding of the auricular cartilage. To accomplish natural folding, nonabsorbable sutures are placed. After repair of the posterior wound, a compulsively applied "formed" dressing must be constructed so that even pressure is applied to the ear for two to five days. The dressing also serves a protective function especially in children.

Collagen Injections

Improved treatment of wrinkles and post acne scars is now possible because of the availability of injectable collagen from a bovine source (Zyderm®). This material is available in a suspension suitable for injection through a fine bore needle. The preparation of this material is a most interesting one of the enzymatic digestion of the telopeptide portion of the triple helix molecule. The telopeptide portion is apparently accountable for the antigenicity of this material and its removal allows for the injection of collagen across different species. It is most important to be sure that the proposed patient is not allergic to the collagen material. A skin test involving an injection of 0.1cc beneath the forearm skin is closely observed for one month prior to the clinical use of collagen implants.

Many surgeons have found that the injection of this material in several of the lines of facial expression and in postacne scars in three or four separate sessions has been a most satisfactory remedy to improve wrinkles and acne scars. However, as the procedure is still a fairly new one, the long term results

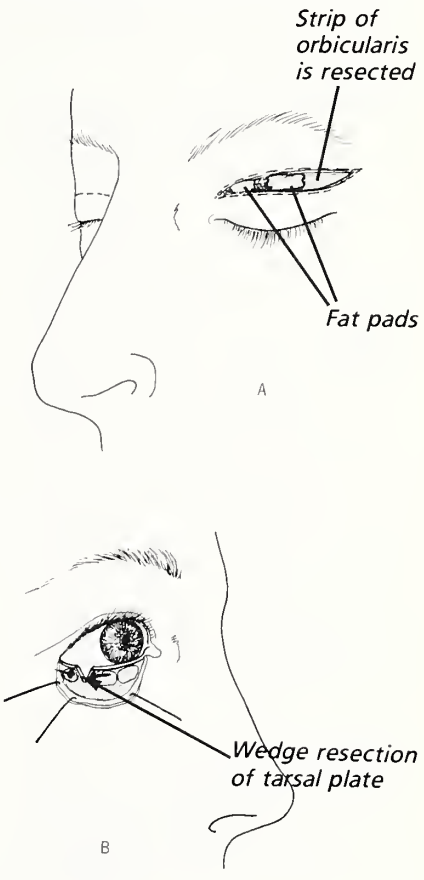


Figure 3
Upper blepharoplasty and tarsal wedge blepharoplasty

Figure 4
Upper and lower lid blepharoplasty



Figure 4A (Before)

Figure 4B (After)

of the injected collagen are not clear and many question its permanence. It does seem to serve as a matrix for the growth of autologous connective tissue. The potential for long lasting improvement exists. Patients are attracted to the non-surgical nature of these treatments. To alleviate much of the discomfort of the injections, the substance is mixed by the manufacturer with .05% xylocaine.

Many patients who previously were poor candidates for dermabrasion because of the rolling, wide and extensive nature of their scarring are good candidates for collagen injection. In fact, the combination of dermabrasion and collagen injection often achieves good results.

Most importantly, the surgeon should emphasize the realistic expectations involved in all procedures, particularly this one. While surgeons hope for improvements in acne scarring and facial lines with collagen injection, they cannot realistically expect a total resolution of these problems. Most properly counselled patients are pleased with the results. However, a rare exception does occur.

Dermabrasion

Sanding of facial skin, using a power-driven sanding wheel, is a technique available to improve certain acne scars and is occasionally used for treatment of wrinkles, particularly in the perioral region. In some cases repeated dermabrasion is necessary to obtain the optimal result. However, care must be taken to avoid the production of scarring and pigmentary changes in the facial skin. Extensive dermabrasion is often performed with the patient under general anesthesia. However, with appropriate facilities, dermabrasion can be done in an outpatient setting.

Chemical Face Peel

Chemical face peel is a very dramatic facial rejuvenation procedure. Using a phenol-based solution, a controlled chemical burn of the skin is achieved. When combined with proper occlusive taping of the skin, peeling greatly alleviates generalized facial wrinkles for many individuals. Pigmentary problems can occur, but results are very satisfactory in most cases.

The even application of the phenol solution and the patience of the surgeon during its application are keys to the safety of this procedure. Because of the potential for renal and cardiac complications, careful preoperative studies of kidney and cardiac function are essential. Usually chemical face peel is performed on an inpatient basis with proper cardiac monitoring intraoperatively.

After chemical face peel the patient must follow a very careful post-operative regimen to avoid pigmentary disorders. For example, prolonged exposure to the sun must be avoided for several months. The formula for phenol solution is phenol 88% U.S.P. 3cc; septisol 8gtts; croton oil 3gtts; and distilled H_2O 2cc.

Rhinoplasty and Mentoplasty

These are procedures which are directed to improvement in contour of the nose and chin region. Often these two structures are considered in tandem, as the overall profile is largely a combination of these two anatomical areas. Rhinoplasty is one of the most frequently performed cosmetic surgery procedures; about 55,000 are performed each year in the U.S.

Differing approaches must be taken to achieve the desired appearance of the nose for male and female patients. Usually a more conservative resection of the nasal dorsum in the male is desired to preserve what is generally held to be a masculine appearance. However, the individual patient's desires, combined with the surgeon's aesthetic judgment, should be taken into consideration in carrying out surgery in this area.

Nasal plastic procedures have been performed for many years and have progressed from relatively indelicate, although clever, procedures to those which can be con-

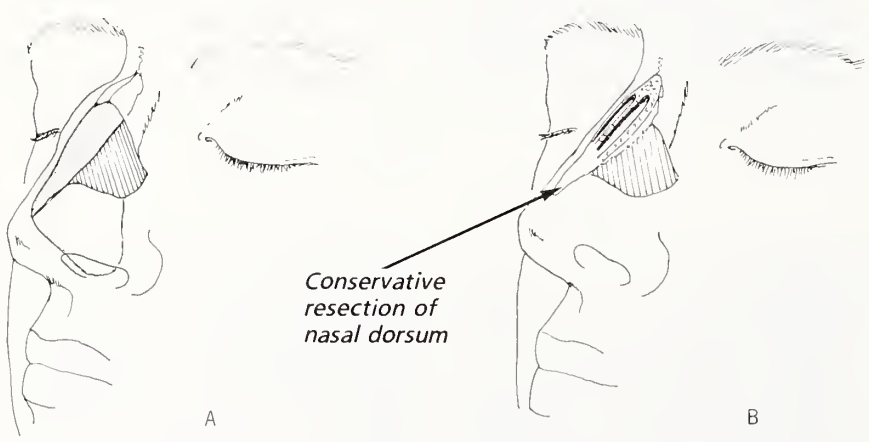


Figure 5
Rhinoplasty

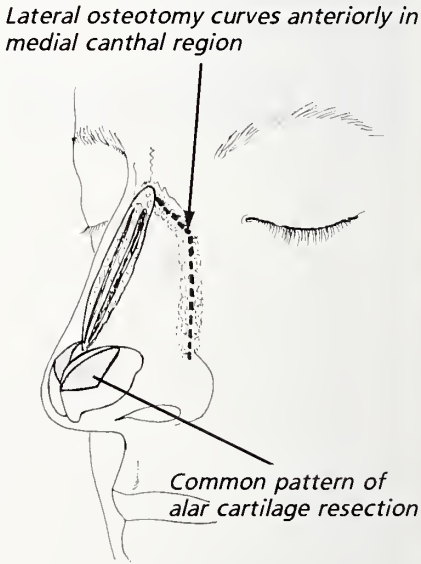


Figure 6
Rhinoplasty

Figure 7A (Before)

Figure 7B (After)



Figure 7
Rhinoplasty

trolled better and yield more predictable results. Functional improvements often can be rendered simultaneously by work on the nasal septum and nasal turbinates. Many of these operations are carried out on an outpatient basis and under local anesthetic with an intravenous sedative.

Swelling and bruising after a nasal plastic procedure can be diminished by altering techniques of lateral nasal osteotomy. The basic steps include first a lowering of the nasal dorsal profile, using various rasps, through appropriately placed endonasal incisions and removing a minimum of bone in an effort to preserve a normal nasal dorsal profile. The dorsal aspect of the septum and upper lateral cartilages can also be conservatively resected.

The second step is directed at the refinement of the nasal tip. In most cases a trans-cartilaginous incision can be made at the level selected, above which the alar cartilage is resected. By minimizing the undermining and trauma of the tip area and by resecting only those cartilage segments necessary to attain the desired result, the early swelling and later contrived appearance of an over-operated nasal tip can be avoided. Various additional maneuvers to score or alter the remaining alar cartilage rim can then be carried out to further refine this area.

The third step involves the lateral osteotomy to narrow the nasal bones and form a normal nasal dorsal appearance. These can be done in a number of ways but usually a guarded osteotome is used to divide the nasal bones or nasal process of the maxilla at a suitable level. Care must be taken near the medial canthal region to avoid trauma by an unnecessarily low placement of the osteotomy. As the nasal radix cannot be truly narrowed, it is not necessary to carry the osteotomy high in this region.[8] An anterior course for the osteotome is preferable. Infracture of the bones is then carefully peformed. (See Figures 5 and 6).

During the surgery, a septoplasty may be performed using conservative, or even radical techniques to score and divide the septal cartilage and bone. More extensive splinting and packing regimens may be necessary if work on the septum has been radical.

A mentoplasty can now be carried out through an incision in the lower buccal sulcus or externally through a submental skin incision. The route chosen will depend upon the surgeon and the patient's concern regarding the possibility of external scarring. The submental incision generally heals well and the resultant scar is of no lasting consequence. A properly sized and shaped pocket in front of the mental prominence is made, usually using a subperiosteal dissection. The dissection is relatively bloodless. A suitable chin implant prosthesis is chosen for insertion at this time either with or without a dacron patch for fixation.

The nasal wounds are then closed with an absorbable suture material usually consisting of 4-0 plain catgut and the chin incision is closed with an appropriately layered closure. A dorsal nasal splint is constructed and applied and endonasal packing is usually inserted and left in place for 24 hours. When the nasal splint is removed in about one week, there is swelling and ecchymosis of the nasal and periorbital areas. Usually this is moderate and within another week generally subsides considerably. At this time most patients have a very satisfactory appearance and are pleased with the result of their surgery. However, during at least the next six months there will be continued gradual improvement of the appearance as the last swelling of the nose and chin subsides.

The patient can expect a gradual return to normal activities with a wait of up to six weeks before returning to full athletic activity

Figure 8A (Before)

Figure 8B (After)



Figure 8

Male rhinoplasty with chin augmentation

and/or contact sports.

Figures 7 and 8 show before/after photos of patients who have undergone nasal/chin alterations.

Hair transplantation

Replacement of hair is most often requested by men who have lost hair in the male baldness pattern. Physicians often are called upon to replace loss primarily in the frontal and vertex scalp regions. The goal here is to produce a result which looks as natural as possible. To reach this aim it is often necessary to combine both the use of rotation flaps for the frontal hairline and 3-4mm plug grafts more posteriorly. Rotation flap reconstruction is most attractive as it produces an "instant" frontal hairline.[9] The remainder of the reconstruction is performed with plug grafts in multiple stages, gradually filling the bald area as well as possible. Nowhere in plastic surgery are clear consultation and true informed consent more important than in hair transplantation. The surgeon's limitations must be clearly understood.

Combined Procedures

Many of the facial cosmetic operations can be performed in combination. The surgeon must take a prudent and cautious approach as an improper or overly aggressive combination of procedures will lead to a greater complication rate. It is not uncommon to perform blepharoplasty, meloplasty, mentoplasty and even nasal tip surgery during a single operating session. It is likewise not uncommon to perform a full rhinoplasty and upper eyelid blepharoplasty together. Collagen injections can be accomplished as an adjunct to many of the surgical procedures. Perioral chemical face peel is properly combined with a meloplasty where perioral wrinkles are of concern to the patient undergoing facial rejuvenation. However, it must be emphasized that a more extensive chemical skin peel cannot safely be performed with extensive undermining as is carried out in a complete meloplasty.

By following certain rules, complication rates for facial cosmetic surgery are very low, as they must be for such elective surgery.

Next month, Part II of this series will include information on plastic surgery of the breasts, trunk and extremities.

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Acknowledgement

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Lymphoma of the Duodenum

Surgical Grand Rounds are held weekly on Tuesday at 5:00pm in the Offield Auditorium of the Passavant Palvilion of Northwestern Memorial Hospital. This case was presented on July 19, 1983.

Dr. John Beal: A 59 year old white woman was admitted, complaining of severe generalized pruritus of five weeks' duration. Symptoms were not relieved by topical applications. Two weeks before admission she noted that her urine had become dark. Ten days later, she found that her stools were light in color and more frequent. For approximately one month she had had postprandial periumbilical discomfort. There was no radiation of the discomfort, which was not severe, and she denied nausea, vomiting, food intolerance, melena or weight loss.

On physical examination her blood pressure was 120/70, temperature 96.5°F, pulse and respirations normal. Her sclerae appeared to be icteric. Head, neck, and chest examination was unremarkable. Her abdomen was soft without masses or organomegaly. Stool was guaiac negative. Laboratory findings included a hemoglobin of 13.5gm., hematocrit 41.5%, RBC 4.08, WBC 6200, SGOT 90, alkaline phosphatase 1530, bilirubin 2.3. Urinalysis: specific gravity 1025 with 1+ bile, otherwise unremarkable. Coagulation tests were normal. Imaging studies were performed.

Dr. Kenneth Pearlman (Radiology): The radiologic evaluation was performed with ultrasonography first, followed by computerized tomography and then an upper gastrointestinal barium study. Radiologically, the diagnosis was difficult. As we scanned the right upper quadrant, we noted that the gallbladder lumen was distended but stones were absent. The pancreatic head was enlarged, however, and the tail of the pancreas appeared normal. The common bile duct, as measured by ultrasonography, measured 11mm. in diameter, markedly abnormal, and the pancreatic duct measured 5mm. We recommended a CT scan to evaluate the pancreas. In the region of the head of the pancreas, we detected a large circular mass which, correlating with ultrasound, we would presume to be the enlarged bile duct. Subsequently an upper GI series was performed. The stomach was normal. However, second and third and perhaps fourth portions of the duodenum were abnormal. There were thickened nodular folds, with a marked distortion of the second and third portion of the duodenum. A 90 minute study of the small bowel showed the same distortion was residual barium in the stomach for four hours.

The question remained as to whether this was a pancreatic mass or a duodenal mass. Ultrasound and CT scans suggested a pancreatic mass and the upper GI examination was compatible with a pancreatic mass with extension into the duodenum. We also considered lymphoma because lymphoma and lymphosarcoma commonly ulcerate. However, lymphoma of the duodenum is very uncommon.

Dr. John Beal: ERCP was performed by Dr. Robert Craig, who found a large mass in the descending and transverse duodenum, involving the ampulla of Vater. It appeared to be friable and slightly ulcerated. He was unable to locate the papilla of Vater and thus did not cannulate either the common bile duct or the pancreatic duct. Biopsies were obtained and reported to be atypical lymphoid infiltrate.

As a result of the findings from radiologic studies and ERCP, surgery was undertaken 10 days after admission. At the time of operation the patient was found to have a large mass in the region of the head of the pancreas. The remainder of the abdomen was unremarkable. The common bile duct was dilated. The gallbladder was markedly dilated but the liver appeared to be unremarkable and the spleen was of normal size.

The initial step was to mobilize the head of the pancreas and to search for lymph node involvement.

A number of lymph nodes were found, submitted for frozen section and were unremarkable. Transduodenal biopsy of the pancreas was performed. The pancreatic head was thickened and the body was felt to be indurated but pancreatic biopsy demonstrated pancreatitis. Accordingly, the duodenum was opened. The common bile duct was opened and the gallbladder removed. The wall of the duodenum was found to be markedly thickened. The entire mass lay within the wall of the duodenum, extending from the second portion of the duodenum as far as one could reach into the third portion of the duodenum. Two or three biopsies were taken of this submucosal mass.

As a result of the frozen section diagnosis, a long-arm T-tube was placed through the common bile duct into the duodenum. The long end of the T-tube extended well into the fourth portion of the duodenum. The duodenal biopsy site was closed with some concern and great care because even that portion of the duodenum seemed to be infiltrated with the tumor. Pathology will provide a report of the histologic findings.

Dr. Kent Nowels: An adequate biopsy specimen of the duodenum was provided showing villae lined with columnar epithelium and a dense cellular infiltrate in the *lamina propria*. With a higher power magnification, these cellular infiltrates are seen to consist of round cells with small hyperchromatic nuclei. The cells were pleomorphic rather than uniform. Most were not spherical but rather somewhat angulated, suggesting lymphoma. The cellular infiltrate consists basically of two population cells, one having small round hyperchromatic nuclei. A bone marrow core biopsy was performed and evidence of tumor was absent.

Dr. John Beal: The patient had an uneventful postoperative course. Radiation therapy was administered on an outpatient basis. The T-tube was removed and combination chemotherapy was instituted.

Lymphoma of the Gastrointestinal Tract

This patient offers an opportunity to analyze certain aspects of malignant lymphoma of the gastrointestinal tract. Later, Dr. John Merrill will discuss some of the specific points about lymphoma of the duodenum and its treatment.

Table 1*
Ann Arbor Staging Classification of the Lymphomas

Stage I. Involvement of a single node region (I) or of a single extralymphatic organ or site (I_E)
Stage II. Involvement of two or more lymph node regions on the same side of the diaphragm alone (II) or with involvement of limited, contiguous extralymphatic organ or tissue (II_E)
Stage III. Involvement of lymph node regions on both sides of the diaphragm (III) which may include the spleen (III_S) or a limited, contiguous extralymphatic organ or site (III_E) or both (III_{ES})
Stage IV. Multiple or disseminated foci of involvement of one or more extralymphatic organs or tissues, with or without lymphatic involvement.

**From Gray, G.M. et al.: "Lymphoma Involving the Gastrointestinal Tract," Gastroenterol 82, 143-52, 1982.*

The American Cancer Society estimated that 23,000 new cases of non-Hodgkin's lymphoma would be detected in 1980 and that 12,400 persons would die from this disease in that year. They predict that 10%-12% of those new cases would initiate in the gastrointestinal tract. This is the most common site of primary extranodal lymphoma and it is considered to be primary in origin there when it is the principal site of disease involvement.

Lymphoma of the gastrointestinal tract involves both sexes and predominately strikes persons of middle age. The stomach is the most frequent site of involvement of gastrointestinal lymphoma, followed in frequency by the small intestine and the colon. According to Brady, as of 1979, 1400 cases of gastric lymphoma and 475 of intestinal tract lymphoma have been reported in the literature. Gastric lymphoma has a better prognosis than either small bowel or colonic lymphoma. Lymphoma of the small intestine usually involves distal small bowel and only rarely is located in the duodenum or in the proximal jejunem. In a very cursory review of collected series, I was able to find only one patient with duodenal lymphoma. Although primary gastrointestinal lymphoma usually presents as a single lesion, multiple lesions in the small bowel and in the colon occur in 1%-20% of cases. The tumors arise from the lymphoid tissue of the *lamina propria* and continue along the submucosa. Widespread disease is often already present when lymphoma of the small intestine is detected. Abdominal pain, weakness and weight loss are the most common complaints. Gastrointestinal bleeding does occur but it is more common in patients with gastric lymphoma than with small bowel lymphoma.

In a series of 112 patients with primary gastrointestinal lymphoma from Charity Hospital in New Orleans, 22% were located in the small intestine. Only four of these manifested gastrointestinal bleeding. These 112 patients ranged from 4-89 years of age with a mean age of 56 years; however, 75% were over the age of 50 years. A mass was palpable in 30% and the hematocrit level was below 35% in 40% of the patients. A curative resection was performed in about one-half of the patients with small bowel lymphoma. It is interesting that the diagnosis is usually made at the time of operation or by the pathologist on the resected specimen. In the series from New Orleans, the lymphoma involved the ileum in 19 patients, the jejunum in four. As I mentioned earlier, they had one case involving the duodenum. The fate of the patient with the duodenal lymphoma was not specified.

Histologic subtype of the lymphomas, as well as the extent or stage of the disease, are important factors in prognosis. Dr. Merrill will discuss some aspects of the histologic types. Patients who have localized disease usually are subject to surgical resection of the tumor. The

diagnosis is established in this manner. Radical surgical procedures are usually not indicated. Limited surgical resection appears to be adequate and postoperative radiotherapy is indicated. Using the Ann Arbor Staging Classification (see Table 1), the probability of cure is approximately 75% for Stage I_E patients. In Stage II, the prognosis, in general, is 25%-40% for a cure rate. This latter figure will probably be improved by the addition of chemotherapy. Most of this information is based on experience with resection and radiotherapy. The problem is more complicated with Stage III disease. Long term control can be expected somewhere between 25%-40% both in Stage III and Stage IV.

Alternative Treatment Methods

In this patient the decision was made not to resect because of the magnitude of the operation for a disease that could be treated by other means. Dr. Merrill will discuss some of the implications of this decision and the method employed in this patient.

Dr. John Merrill: This patient presented findings that required an approach to the lymphoma problem which was different from the customary approach. In the most common situation, the surgical role is one of biopsy of a suspected lymph node. Thereafter one begins to plan the diagnostic steps that establish ultimate therapy. It is important that the diagnostic assessment and therapeutic planning are correlated. Staging influences therapy and has prognostic significance.

This patient's management was influenced by the presence of obstructive jaundice. Although lymphoma was considered, the important aspect of her treatment was decompression of the biliary tree. The operation also provided the initial step in staging as well as classifying the lymphoma.

As indicated earlier, this patient was found to have a non-Hodgkins lymphoma of the gastrointestinal tract, which is unusual because it involves the duodenum. There are certain differences between Hodgkin's and non-Hodgkin's lymphoma. The latter is a rather heterogeneous group that includes lymphocytic lymphoma and histiocystic lymphoma. In the future, it will be less confusing to classify lymphoma as either Hodgkin's or non-Hodgkin's. There are certain clinical differences between these two categories of lymphoma. Typically Hodgkin's patients are younger than the non-Hodgkin's patients. It is very unusual for Hodgkin's disease to present in an extranodal fashion, but not at all uncommon for the non-Hodgkin's. Most non-Hodgkin's lymphomas present at a more advanced stage, at least a regionally advanced stage, rather than a limited Stage I or Stage II. Hodgkin's is more frequently detected at an earlier stage.

Hodgkin's disease also tends to spread in a more predictable fashion. It would be extremely unusual for Hodgkin's disease to appear in supraclavicular nodes and inguinal nodes without disease between these areas. In contrast, non-Hodgkin's lymphoma may be detected simultaneously in the gastrointestinal tract, mediastinal nodes, and bone marrow.

Our understanding of the pathology of lymphoma is changing as more knowledge is gained about the immunology of the lesions and the function of B cells and T cells. Such information now influences therapy.

When limited, some gastrointestinal lymphomas are curable by surgical resection; in fact, Brady indicated that surgical resection followed by radiation therapy was preferred for Stage I and II gastrointestinal lymphomas. However, a review of the Brady paper indicated a cure rate of no better than 50% in these favorable lesions. When one considers the treatment of advanced lymphoma, with involvement of nodes on both sides of the diaphragm, bone marrow and liver, chemotherapy produces prolonged survival in 50% of such patients.

The patient presented today was operated upon to establish the diagnosis and to relieve the biliary tract obstruction. Radiation was selected as the initial method of treatment so that the T-tube could be removed in six to eight weeks and the danger of bacterial invasion of the biliary tree diminished.

When the T-tube was removed, we could depend on reasonable hepatic metabolism. Thus, after radiation, five drug chemotherapy was instituted. She is now tolerating this program as an outpatient. The five drugs are cytoxin, adriamycin, vincristine, prednisone and bleomycin. We assume that she has systemic disease. Review of the bone marrow aspirate has been equivocal and one observer suggested that abnormal lymphocytes were present in one area.

In conclusion, this complex case illustrates the advantages of cooperation between the disciplines of surgeons, radiotherapists and chemotherapists in the development of appropriate treatment of an unusual manifestation of lymphoma.

Dr. Lawrence Michaelis: Why did you do a cholecystectomy?

Dr. John Beal: By virtue of having to place a long-armed T-tube through the sphincter of Oddi, which had to remain in place for a matter of weeks, she was exposed to prolonged reflux of the gastrointestinal tract contents in the biliary tract. Cholecystitis is a potential complication under such circumstances and is prevented by cholecystectomy. ◀

The Origin of Medical Isolationism in America

By John L. Graner, M.D./Hines

Meaningful interaction between private and academic physicians is rare, although both are very concerned about the quality of medical training in the United States. Osler foresaw more clearly than most the potential shortcomings of full time medicine. A brief look at the physicians responsible for the establishment of America's first full time program (at Johns Hopkins) is presented. The rift between academic and private medicine must be mended, perhaps at the level of the local medical society.

Recently, while attending a subspecialty medical course, I found myself on an elevator with two of the course's lecturers. They were both nationally known "experts in the field." As I rode with them, one man disdainfully said to the other, "What a long session. I just can't understand how those characters can sit there all day." The term "those characters" referred to the audience, a group of specialists and subspecialists in private practice. The other man, noting by my name tag that I was probably one of them, only nodded. An awkward silence ensued until they left the elevator.

Throughout the conference, presenter intolerence to some of the less "enlightened" questions from the audience was obvious. Answers were often curt and impolite. Although microphones were available for questions, by the third day of the conference the audience chose not to use them!

I admit that open hostility of this sort is unusual, and may have arisen through a set of rather unique circumstances. However, it served to point out well a lack of the "unity, peace and concord" which should exist between academic and private physicians.

Only infrequently is there any meaningful interaction between these two groups. My experience is that cliques are formed among university physicians which exclude nonacademicians, and the strain between the two factions is obvious to me whenever they come together.

How did such a situation come about? I maintain that this strain is at least partly due to poor planning. Since they were the first school to go full time, Johns Hopkins is an important example.

Historical Notes

In 1913, full time academic medicine's "founding fathers" at Johns Hopkins forgot something. That is, they neglected to include a means through which the academic physician could keep in closer contact with his private colleague and the community at large. It is noteworthy that in the case of Johns Hopkins this obvious lack of planning occurred despite William Osler's repeated warnings.

Early on, Osler foresaw the shortcomings of the full time system and spared no effort in pointing them out. To him, good rapport between academic and private physicians was of primary importance. Speaking to his fellow (part time) teachers in 1902, Osler expressed his feelings regarding the private practitioner: "a well-trained, sensible doctor is one of the most valuable assets of a community, worth today, as in Homer's time, many another man. To make him efficient is our highest ambition as teachers, to save him from evil should be our constant care as a guild."[1]

But it was also with a deep sense of urgency that in the same speech Osler made these comments: "Lack of systematic personal training in the methods of the recognition of disease leads to the misapplication of remedies, to long courses of treatment when treatment is useless, and so directly to that lack of confidence in our methods which is apt to place us in the eyes of the

public on a level with empirics and quacks."[1]

It is clear from the above quote that Osler was well aware of the educational deficiencies which then existed. Despite this, he was leary of the prospect of full time appointments. Why? I think because he feared that the spirit of full time, although probably conducive to the development of medical science, was a threat to the humanistic aspects of medicine.[2] Did Osler also foresee full-time ultimately leading to a deterioration in the relationship between the medical center and the community, and therefore between academic and private medicine? Perhaps not, but certainly he would not have been surprised at such an outcome.

The following is an excerpt from a letter which Osler wrote to the president of Johns Hopkins in 1911: "The danger (of the full time system) would be the evolution throughout the country of a set of clinical prigs, the boundary of whose horizon would be the laboratory, and whose only human interest was research, forgetful of the wider claims of a clinical professor as a trainer of the young, a leader in the multiform activities of the profession, an interpreter of science to his generation, and a counselor in public and in private of the people, in whose interests after all the school exists. And remember, what we do today, the other schools will try to do tomorrow."[3]

Who were the physicians at Johns Hopkins most responsible for the establishment of the full time system?

It was the then chairman of anatomy at Johns Hopkins, Franklin Mall, who was the chief proponent of the full time system in America. His enthusiasm for the full time concept was kindled while training in Germany, as Mall was much impressed by the ideas of his former teacher, Carl Ludwig. Although a great researcher, all reports indicate that Mall was anything but a clinician. He spent most of his day in the laboratory, and had little time for such mundane tasks as even that of teaching his own anatomy course (the "inductive method" of teaching)! Mall's relations with private medicine for all practical purposes can be said to have been nonexistent.[4]

Certainly William Welch, the chairman of pathology, was aware of the "inbreeding" which was to result from such a system. Quoting Welch and his biographers: " 'One of the great benefits to be expected from the suggested (full time) plan is the wide extension of this field by the training of men for the higher clinical walks.' Once the new system was established, it would create its own professors, who had never become used to living on the scale of successful practitioners."[5]

Welch was a man of remarkable intellect, and Osler considered him to be the "ablest of the (Hopkins) group"[6] He was, however, basically a laboratory man. He could not relate to private medicine as could Osler, who himself had a large private practice. He therefore probably did not well appreciate Osler's fears.

And what of Lewellys Barker, who became Osler's successor as the chairman of medicine at Johns Hopkins? He also must be considered an important influence in the development of full time medicine. Barker was much impressed by Mall's arguments for such a system, and in 1902 gave an influential speech entitled "Medicine and the Universities," in which he advocated full time medical appointments. When the time came for him to accept the full time professorship, however, he found that for financial reasons he could not do so.

Importantly, in his later years, Barker also had second thoughts regarding full-time that were not purely financial: "As I write about it now, some forty years later, I am aware of some possible objections to the (full time) plan that, owing to lack of experience, I could not then fully recognize. At the time I had not read Sir James Paget's *Memoirs* in which he stated that 'one who has not studied in both hospital and private practice is not much more than half-instructed in his profession.' "[7] Unfortunately, at the time of full-time's inception, he had no such considerations.

I cannot here discuss Osler's reasons for leaving Johns Hopkins in 1905. Suffice it to say that after he did leave for Oxford, any meaningful opposition to the full time plan ended. Osler realized this when at the close of his last faculty meeting, he turned to Mall and said "Now I go and have your way."[8]

And, of course, after the Hopkins adventure, as Osler had predicted, the other schools soon went full time as well. Medicine in America has since evolved along two separate lines: the private and the academic. Although both have a common ancestor, of which Osler is a good example, they are by now only distant cousins.

Perhaps then, and not only at Johns Hopkins, full time academic medicine came about without enough due concern for its effects upon the brotherhood (and sisterhood) of physicians. Clearly, no mechanism was established for free and easy communication between the private practitioner and the academician. As a result, as Osler had feared, we now have a large subset of professors in our medical schools who certainly are not "leaders in the multiform activities of the profession." We all know the benefits of the full time system—they have been drummed into our heads. And no doubt medical knowledge has grown more rapidly than it would have without it. But I believe that we, like Osler, must realize the division within the profession which the full time system has created.

That this division must be closed is clear. As Cluff points out, enhanced cooperation between university and community hospitals is necessary to improve teaching and patient care, and would "more effectively meet the needs of society."[9]

How may mutual interests and understanding between the two factions again be fostered, and how may we make up for the lack of planning by our predecessors in this regard? Only through friendly meetings, conducted on a regular basis, would this be possible. As it is, meetings involving both parties usually take the form of a lecture given by the academician on his favorite research topic. The audience at such an event often leaves the room wishing the presenter knew more about "just what it's really like out here," and had geared his talk

accordingly. (I once heard a lecturer base his entire discussion of the "practical" management of water balance problems on plasma ADH levels!) This type of thing serves only to highlight the underlying problem.

No, what we need are regular encounters between private physicians and the full time academic staff. Holding such meetings would be a great way of sharing mutual knowledge and experience in a nonthreatening manner. Through such meetings academicians could learn the state of medical art in their community in terms of how patients are diagnosed and treated on a daily basis outside of the university medical center. Also, many diagnostic and therapeutic "tricks" are acquired only through long years of busy practice. The private physician in turn might acquire a greater depth of knowledge regarding the theoretical aspects of diseases he is called upon to manage. As these "friendships of utility" are formed, they might set the stage for the development of deeper relationships.

How the needed informal gatherings can be accomplished must depend upon local circumstances and conditions. Perhaps the local medical society is a good place to begin.

Although I am afraid it will be a major accomplishment to get some of our academic friends to attend, it is worth the effort. The duty of us all is to break down the barriers which divide us, never forgetting the brotherhood of Aesculapius to which we all belong. We must let Osler's warning sound a clear note in our ears. Only through mutual cooperation and understanding may we benefit from our varied experiences and grow as a profession. We may find that "those characters" can teach us as much as we can teach them! ◀

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Physician Recruitment

(Continued from page 166)

67 bed JCAH accredited hospital completing $2 million addition/ renovation in May 1984. Ten active staff members at present. Openings in Family Practice and General Surgery. 75 miles west of Springfield between Illinois and Mississippi Rivers. Recreational facilities abound. Contact: Fred Thompson, 640 W. Washington Street, Pittsfield, 62363, 217-285-2113. (5)

SALEM:
Population 7,800. 70 miles east of St. Louis, immediately off I-57. Need OB-GYN physician to join existing corporation or to practice independently. Existing corporation provides renovated office building less than five minutes from 65 bed JCAH accredited hospital. Guaranteed salary. Contact: Thomas G. Walther, Adm., Salem Hospital, Salem, 62881, 618-548-3194. (4)

STREATOR:
Community of 22,000, serving population area of 70,000. Located 60 miles from Joliet and Peoria. Fully equipped hospital of 248 beds, with 41 physicians on staff. Cardiology, psychiatry and family practice specialities needed. Practice guarantees provided. Interested physicians are asked to send current resumes to: Terence Schuessler, Adm., St. Mary's Hospital, 111 Spring Street, Streator 61364. (4)

Part Two of a Series

Mandatory Reporting Amendments to the Medical Practice Act

At its September, 1983, meeting, the ISMS Board of Trustees endorsed a booklet detailing pertinent aspects of the January 1, 1983, mandatory reporting amendments to the Illinois Medical Practice Act. Development of the booklet had been a joint effort of ISMS, the Chicago Medical Society, the Illinois Hospital Association and the Chicago Hospital Council. A cooperative effort was considered appropriate as each group had a vital interest in the law, its proper administration and uniform understanding by those effected.

Last month, we featured a summary and overview of the amendments (page 122). That feature referred to a question and answer section available as part of the full text. (The complete booklet, which includes sample forms and the law itself, is available from the ISMS offices.) This month, the question and answer section is reproduced in full, to elucidate points made in the initial summary. Pertinent sections of the law or its rules are in parentheses following the answers to most questions.

1. *What individual in each of the entities required to report must make the report?*
For health care institutions, the Administrator or Chief Executive Officer must make the report (Sec.16.04a.1.) For professional associations, the president or top staff person makes the report (Sec.16.04.1.2.) The law does not specify who within an insurance entity or public agency is to make the actual report, though it should be someone in a responsible position. (Sec.16.04.a.3-5)

2. *How long after a final action has been taken on a physician's behavior or practice does one have to file a report?*
Reports are to be filed within 60 days after an action has been taken (Sec. 16.04.b).

3. *What are the important factors to consider prior to reporting an impaired physician?*
First, a written, clinical determination must be made by the facility and its medical staff that a physician is, in fact, "impaired", or alternatively, the physician must admit to the hospital that he has an impairment which has been clinically verified; and
Secondly, the physician must have been placed "under supervision" as defined by the rules. (Sec. 16.04.a.1.)

4. *How does a hospital or association know if an action it has taken is the result of a physician's "unprofessional conduct," and therefore, should be reported?*
Following an action against a physician by one of the required reporting entities, the reason for the action should be compared with the provisions defining "unprofessional conduct" in the Medical Practice Act and its rules. Should the action against a physician fall within one of the unprofessional conduct criteria, or violations of the act, then a report would be required. (Rule 290.30 and Sec.16)

5. *Could a physician's actions outside the health care institution be a subject of a report?*
Potentially, yes. The law requires the States Attorneys to report any felony convictions of a physi-

cian. Public agencies are required to report violations of the Medical Practice Act, and incidents of unprofessional conduct that come to their attention in the administration of their programs and activities. Professional associations are required to report any incident of unprofessional conduct directly related to patient care coming to their attention. In addition, the rules permit anyone to complain about a physician (Sec. 16.04.a.2-5,Rule 8.01)

6. *If a physician seeks treatment or is a patient in a hospital for an impairment, does the hospital have to file a report?*
No. The law does not require reporting of physicians who voluntarily seek help from medical providers or facilities.

7. *If a physician has privileges temporarily reduced for non-disciplinary reasons, is a report required?*
It depends upon whether the reason for the reduction of privileges is based upon a final determination of unprofessional conduct or impairment directly related to patient care, as defined in the law. An example of when a physician does not have to be reported is a temporary physical incapacity. (Sec.16.04 a.1.)

8. *Does a hospital have to report physicians whose clinical privileges are reduced during the reappointment process, whether or not it is a voluntary reduction or one recommended by the medical staff?*
It depends. The deciding factor is whether or not the reduction is the result of a final determination of unprofessional conduct or mental or physical disability as these terms are defined in the law. For example, elderly physicians who no longer desire to perform surgery need not be reported. (Sec.16.04.a.1.)

9. *A staff member has been kicked off our Staff for unprofessional conduct and is now fighting the decision in court. Do we submit a report to the MDB now, or must we wait until the court proceedings are finished?*
The law states that reports are to be submitted when a final determination has been made by the governing body of the institution. Therefore, even if the case is in court, your hospital has already made its final determination, which is reportable. (Sec. 16.04.a.1.)

10. *Does the Medical Staff have to report physicians whose services are questioned by one of the Staff committees, i.e., Tissue, UR or Pharmacy?*
No. The Medical Staff itself will not report to the state. Should a physician be identified as impaired, incompetent or otherwise considered to be unprofessional, no action of the Staff will result in a report. Only actions of the Governing Board in accordance with the bylaws or voluntary action by the physician in lieu of Board action will result in a report. (Sec. 16.04.a.1.)

11. *Our Medical Staff is organized as a "professional association". Must we report incidents of unprofessional conduct or impairment if the hospital already has reported the physician?*
No. The regulations governing the law state that the term "professional association" does not include hospital medical staffs. (Rule 290.30)

12. *Should a physician who is disciplined for not completing his medical records, or not attending staff meetings, be reported?*
This depends upon the hospital's rules and the effect the physician's action or inaction has on patient care. If a patient is in the institution and the records are not complete, the care of the patient may not meet acceptable standards. However, if a patient has been discharged, and the records have not been completed, the issue may be one of insurance reimbursement, rather than quality of care. Lack of attendance at Medical Staff meetings is generally an administrative matter and is not reportable. The most important factors in determining whether a hospital action requires a report are whether or not the physician's conduct, which resulted in a final determination for restriction or termination of privileges was directly related to patient care, and was of an unprofessional nature. (Sec.16.04.a.1.)

13. *Does the hospital have to report impaired nurses to the state?*
A recent amendment to the Ill. Nursing Act, effective Jan. 1, 1985, requires nurses in an administrative or official position in a health care facility to report to the Dept. of Registration & Education nurses who are habitually intoxicated or addicted to drugs, or who divert drugs for their own use.

14. *Should a physician who is reported retain services of an attorney?*
Once a report is filed, the legal process leading to possible discipline is commenced. Anything a physician says, does or fails to do can have an impact on the outcome of the process. Given the disciplinary nature and complexity of the process, a physician should give serious consideration to retaining legal representation from the very beginning.

15. *Can the state revoke or suspend the license of a physician who is reported for disciplinary actions?*
Yes. While in most cases the actions of a health facility or professional association will merely be filed by the state, if a violation of the Medical Practice Act is found, the potential of license suspension or revocation does exist. Merely because a report is referred by the Disciplinary

Board for investigation does not mean the physician will be disciplined by the state. A number of steps, including a full administrative hearing process, must be followed when a formal complaint is filed alleging a violation of the Act, prior to any discipline being taken by the state. (Sec.16.)

16. *Will a patient be notified that a physician treating him or her has been reported to the Medical Disciplinary Board?*
Patients may be requested to give their permission for releasing the medical record of their care under a physician who has been reported if the state finds the report does not provide sufficient information to enable the Medical Disciplinary Board to make a decision to close or further investigate a report. The state does not intend to contact patients of impaired physicians, though the rules do reserve this right if necessary. (Rule 290.55.6.4)

17. *Will a patient, whose consent has been requested, be notified of the determination of the MDB based upon the report?*
If the state has contacted a patient about a report, that patient will be informed of the outcome of the report disposition or case investigation.

18. *Will hospitals and medical societies receive copies of reports or find out who has been disciplined?*
Statistical reports, without names, listing number of reports filed by each type of entity, reports closed and opened, and impaired physicians reported, will be sent to hospitals and state professional associations every other month. (Sec.16.04.f.) If a party requests, R&E will send monthly reports of disciplines on all types of health personnel. If during the credentialing/reappointment process, a hospital or association wants information regarding reports filed on membership applicants or current Staff members, this should be requested from the physician, since each physician reported will receive notification of those reports and their ultimate outcomes. (Sec. 16.04.e.)

19. *Will a patient's records have to be submitted along with the report?*
No. While, the official reporting form asks for medical records, the law does not require the records accompany reports, nor can they be submitted without patient authorization. (Sec.16.04.b.3.)

20. *Will hospitals, medical societies, newspapers or other groups or individuals have access to the reports?*
No. The reports and their contents are strictly confidential and will not be available to anyone other than the Disciplinary Board, designated R&E staff, the maker of the report and the subject of the report. (Sec.16.04.6.6)

21. *If a physician is the object of a claim or suit, must an insurer report this to the MDB?*
No. Only awards and settlements in favor of the plaintiff, alleging negligence will be reported to the MDB. (Sec.16.04.1.3) While the official report to be filed by an insurer does request a listing of all previous claims or suits against that physician that are contained in their files, no such requirement exists in the law.

22. *Must the MDB give prior approval to rehabilitation programs for impaired physicians?*
No. However, the MDB has the power to review and direct modifications in the rehabilitation program if it finds the program inappropriate or insufficient in dealing with the physician's problem. (Rule 290.55.a.)

23. *Will ISMS' Committee for the Impaired Physician or a hospital's medical staff committee for impaired physicians have to report physicians they assist?*
No. Only the society's or hospital's governing authority can make final determinations on whether a person is impaired, and that body will make the report if appropriate. However, if the hospital does make such a report, the committee may be asked to assist in a physician's supervision or in the development of progress reports. (Sec.16.04.a.1&2.)

24. *If a county medical society member is found by our society's Peer Review Committee to have violated one of the provisions of the "unprofessional conduct" section of the act, does the society report the physician at that point or wait until the physician has appealed the case to ISMS?*
It is our understanding that since county society members have the right to appeal local decisions to the ISMS Judicial Panel, no report would be required until an appeal has been accepted and the decision reported back to the county society. (Sec.16.04.a.2.)

25. *If a physician has been found to be impaired and violates the terms of his or her supervision or rehabilitation, will the MDB initiate disciplinary proceedings based on the original report?*
No. The law prohibits the state from using or making available information contained in an impaired physician report for any other administrative proceeding. Conceivably, if an impaired physician was not cooperating with his or her supervision, the health facility would have to discipline the physician and file a new report with the state. (Sec.290.55.d.3.)

Abstracts of Actions

(Continued from page 149)

MANDATORY LEVELS OF LIABILITY INSURANCE

In response to Resolution 15 (A-83), Mandatory Levels of Liability Insurance, which was referred to the Board for study, the Board approved an Old Business Report recommending that the following substitute resolution be adopted in lieu of Resolution 15:

RESOLVED, That the Illinois State Medical Society reaffirm policy pertaining to required liability insurance by hospitals; and be it further

RESOLVED, That the Board of Trustees develop a mechanism through appropriate councils and committees to assist hospital medical staffs in addressing the issue of required liability insurance as a condition of staff privileges.

[Present ISMS policy states that: (A) ISMS be opposed to hospital actions which unilaterally stipulate that professional liability insurance is a pre-requisite for membership on a medical staff; (B) If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees; and (C) To protect their assets members of a hospital medical staff be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and the hospital.]

PROFESSIONAL LIABILITY INITIATIVES

Mr. Robert Teeter, of Market Opinion Research, reviewed the findings of the membership/policyholders survey on professional liability concerns. After hearing an analysis of these results, the Board approved development of legislation which could be introduced into the General Assembly. The legislation would address tort reforms. Under these bills various issues would be addressed to assure that excessive awards are not made for non-economic loss, that wrongfully sued professionals have redress, that plaintiffs do not receive double compensation for insured loss and that plaintiffs are assured a larger portion of awards. In addition, this will assure that a compensable loss is covered in a manner benefiting a patient.

Mr. Teeter pointed out the need for a high degree of activity on the part of all ISMS members if there is to be success in accomplishing reform. The Board agreed there must be intensification of effort to accomplish the goals of reducing the "Malpractice" problem, which was identified by the survey as the single most important issue confronting Illinois physicians.

COMMITTEE ON DRUGS & THERAPEUTICS

The Board approved the following drug products for inclusion in the Illinois Department of Public Aid Drug Manual: Sandimmune 100 mg/ml oral solution-50 mg/ml injection (Cyclosporine); Wollcovorin 5 mg & 25 mg tablet-5 mg/ml injection (Leucovorin Calcium); Hydergine 1 mg liquid capsule (Ergoloid Mesylates); Roxanol 20 mg/ml oral solution (Morphine Sulate); Hep-lock 100 U/ml (Heparin Sodium); Rabies Vaccine and Rabies Globulin.

The Board also recommended that the following drugs not be included in the Drug Manual: Bumex 0.5mg and 1.0 mg tablet (Bumetanide) and Lozol 2.5 mg tablet (Indapamide).

The Board further recommended that Meperidine Elixir be removed from the Drug Manual, and that the drug product Inderal L A be included in the Drug Manual.

OTHER ACTIONS

In addressing various other issues, the Board:

- Directed that the Governor be informed by letter of the recommendation of the ISMS Board of Trustees pertaining to the position of Director of the Illinois Department of Mental Health and Developmental Disabilities.
- Directed that a letter of thanks be extended to each of the members of the Ad Hoc Search Committee for their dedicated activity in assisting with the review process pertaining to the IDMHDD Director position.
- Endorsed a fund-raising raffle at the 1984 Annual Meeting to benefit the ISMS Student Loan Fund.
- Agreed to continue funding our defense of the Wilk case from undesignated funds.
- Directed that ISMS oppose the preliminary recommendations of the State Board of Education to eliminate health examinations for students prior to entering the 5th and 9th grades and that ISMS further oppose the elimination of financial penalties for school districts which fail to comply with student health mandates regarding immunization and health

examination requirements.

- Authorized a letter to the Medical Disciplinary Board objecting to R & E staff activities, with no Medical Disciplinary Board authorization, requiring the submission of non-mandated information from reporting entities under the Mandatory Reporting Act.
- In response to a request from the IDPA State Medical Advisory Committee, agreed to comment on a proposal to add suicide to the conditions deemed to endanger the life of a mother, and therefore, justifying the State reimbursing for an abortion procedure. The following statement was approved:

 "That ISMS recommend to IDPA that the risk of suicide associated with a psychiatric illness be included as a condition which threatens the life of a mother. ISMS further recommends that certification of a potential suicide victim should be done by a psychiatrist whenever possible, but if a psychiatrist is not available, another physician should conduct the evaluation, as long as the physician making the evaluation is not the one performing the abortion procedure."
- Directed that: (1) Existing policy on Third Party Intrusion into Medical Judgment be maintained; and (2) Third Party Payment Processes Committee continue to study a proposed amendment and work on an amended policy.
- Agreed to continue to make an annual $150 contribution to the Interagency Council on Smoking and Disease.
- Selected Drs. Bernard Cahill, Peoria; Robert Hamilton, Chicago; Julius Kowalski, Princeton; Richard Laney, Belleville; and Edward May, Grayslake, as recipients of the 1984 ISMS Team Physician Award. Further agreed to award Certificates of Recognition to all physicians nominated but not selected for the award, for their efforts to improve and protect the health of young athletes.
- Agreed to endorse a research project sponsored by the Illinois Council of Hospital Schools of Professional Nursing on comparisons between diploma nurse programs and baccalaureate programs. No financial support was authorized.
- Approved the selection of other health professions to serve in a consulting role to the Task Force on Health Professions. The initial consulting organizations are the Illinois Hospital Association, Illinois Nurses Association, Registered Physical Therapists, Audiologists, Illinois Chapter of the American Association of Medical Assistants, Inhalation Therapists/Respiratory Therapists, Illinois Occupational Therapists Society, American Society of Radiological Technologists, Dietitians, Illinois League of Nursing, Illinois Council of Licensed Practical Nurse Directors, Illinois Council of Hospital Schools of Professional Nursing, Pharmacists and Retail Druggists.
- Approved for printing and distribution to ISMS officers, county societies, medical staffs and individual members, upon request, the booklet "Physician's Guide to the Illinois Living Will Act."
- Agreed to support, in concept, an IDPH project to assist teen parents, called "Parents Too Soon."
- Approved: (1) A proposed ACCME survey questionnaire for use in recognizing state medical societies as accreditors for intrastate CME sponsors; and (2) That comments concerning summary of the ACCME September 1983, meeting be communicated to ACCME.
- Agreed to: (1) A supplemental retirement plan, 401 (k), for employees, with costs limited to required legal fees for securing government approval; and (2) Revisions to the employee retirement plan by changing vesting requirements for employees hired after January 1, 1984, to 100% after 10 years, and adding restrictions to the withdrawal of employee funds for hardship reasons only, with a one-time withdrawal option without reason prior to July 1, 1984.
- Approved for filing: (1) November 30, 1983, financial statements; (2) December 31, 1983, IMPAC collection data; and (3) December 31, 1983, dues payment report. Further approved requests for changes in membership status as presented.
- Approved the following Unfinished Business Reports for the House:

 Report entitled "Health Insurance Benefits Spelled Out" which recommends that Res. 12 (A-83) not be adopted. The Board also directed that staff meet with representatives of the insurance industry to discuss ways to make health insurance benefits more easily understandable.

 Report entitled "Chronic Care Patients" which recommends that Res. 20 (A-83) be adopted.

 Report entitled "Anti-Trust Law" and "Federal Trade Commission" which recommends that ISMS continue to support AMA efforts to clearly define anti-trust laws and FTC authority over the learned professions and further recommends that this report be adopted in lieu of Res. 22 (A-83) and Res. 23 (A-83).

 Report entitled "Conflicts Between ISMS Bylaws and the Judicial Panel Handbook for the Conduct of Disciplinary Proceedings" which recommends that Substitute Res. 24 (A-83) be adopted.

 Report entitled "Good Samaritan Legislation for Medically Indigent Programs" which recommends that Res. 34 (A-83) not be adopted.

 Report entitled "Freestanding Emergency Centers" which recommends that the Society wait until such legislation is introduced and then take action on Res. 35 (A-83) through the legislative process which is exempt from anti-trust actions, and that this action be taken in lieu of Res. 35 (A-83)
- Approved resolutions which:

 Amend Chapter IX, Section 5 of the ISMS Bylaws by adding the Committee on Hospital Medical Staffs to Committees Reporting Directly to the Board of Trustees.

 Add the following to Chapter IX, Section 8, "Board of Trustees Committees": "The Building and Capital Equipment Committee shall consist of the Chairman of the Board, the President, the President-Elect, the Secretary-Treasurer, the Immediate Past Chairman of the Board and the Chairman of the Finance Committee. The Committee shall review and

monitor activities pertaining to the building and capital equipment."

Call upon the ISMS House of Delegates to continue its strong support of voluntary CME in Illinois and the intrastate accreditation of quality CME programs.

Urge all Illinois hospital medical staffs to develop and conduct educational programs for their hospital staff regarding advances in care that may be provided infants born with disabilities and regarding laws and regulations affecting the delivery of such care.

Address policy: (1) Amended policy statements on "Autopsies" and "The Privacy of Physician Records"; and (2) The retention of the policy statement on "Prolonging Human Life."

APPOINTMENTS/NOMINATIONS

Acting upon recommendations of the councils and Executive Committee, the Board:

- Agreed to submit the names of the following physicians to the IDPA as candidates willing to serve on the IDPA Peer Review and Exception Review Committees:
 Nazir Ahmad, Centralia
 Benjamin Arenas, Belleville
 Thomas Carswell, Peoria
 Ignacio DelValle, Taylorville
 Irwin Hiebert, O'Fallon
 Ronald Johnson, Pleasant Hill
 Eric Lehr, Belleville
 Dorothy Lynch, West Chicago
 Ashok Patel, Centralia
 Dave Schlagheck, Morton
 Edward Spitze, Belleville
 Thomas Wilson, Champaign
- Nominated Dr. Warren H. Staley, Chicago, for the Department of Registration and Education's Medical Examining Committee.
- Nominated Dr. Robert P. Johnson to represent the Society on the Governor's Task Force on DUI.
- Appointed Dr. Kenneth D. Hansen, Carbondale, to the Medical Legal Council.
- Appointed Dr. Richard L. Newman, Quincy, to the Impaired Physician Panel.
- Appointed Dr. Henrietta Herbolsheimer a consultant to the Third Party Payment Processes Committee.
- Appointed Drs. Warren D. Tuttle, Chairman, Phillip D. Boren, Lawrence L. Hirsch, Alfred J. Kiessel, Arthur R. Peterson, Fred Z. White and Mr. Fred Schwartz, to serve on a Task Force on ISMS-Sponsored Membership Insurance Programs.
- Nominated Dean Bordeaux, M.D., Peoria, for the ACCME Committee for Review and Recognition.
- Nominated the following individuals to serve as ACCME site surveyors at accreditation site visits as well as surveyors for the recognition of state medical societies as accreditation granting bodies:
 Randall Bellows, M.D., Chicago
 Norman Brill, M.D., Harvey
 Alfred Clementi, M.D., Arlington Hts
 J. D. Clemmons, Ph.D., Peoria
 Charles Colodny, M.D., Libertyville
 Audley Connor, Jr., M.D. Chicago
 Abraham Fallah, M.D., Harvey
 Allan L. Goslin, M.D., Streator
 Robert Hartman, M.D., Jacksonville
 Terry Hatch, M.D., Champaign
 Lawrence Hirsch, M.D., Chicago
 Harold Jensen, M.D., Harvey
 Robert Johnson, M.D., Springfield
 Alfred Kiessel, M.D., Decatur
 Boyd McCracken, Sr., M.D. Greenville
 Thomas Meirink, M.D., Belleville
 Harold Paul, M.D., Chicago
 Lee Sacks, M.D., Des Plaines
 Fred White, M.D., Chillicothe

MEETINGS

The Board of Trustees:

- Approved a recommendation changing the June 2-3, 1984, Board meeting, to June 9-10, 1984, at the Arlington Heights Hilton.
- Set the next Board of Trustees meeting for April 5-8, 1984, at the Marriott Downtown, Chicago.
- Agreed to hold a Specialty Society Forum on March 21, 1984.

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Percutaneous transluminal coronary angioplasty for patients who exhibit mild coronary artery stenosis may enhance the subsequent onset of acute myocardial infarcts and may precipitate emergency coronary artery bypass grafting. Sixty four patients, mostly men about age 52, were followed for a period of 1-16 months (mean 7.1 mos) and were found to have a more severe stenosis than prior to the percutaneous transluminal coronary angioplasty. (Ischinger, I., *et al: Circulation* 68:148-54 July 1983)

One hundred seventy nine patients with coronary artery stenosis of greater than 50% as documented by coronary angiography had an exercise ECG and a stress thallium scan (141 cases). The stress test was strongly positive in 51 cases. A total of 28 cases showed 2mm ST depression mildly positive; 23 cases showed no ST depression and 77 cases could not be interpreted. The correlation between ST depression on exercise testing and left ventricular function may not be sufficiently diagnostic and thus requires a more total comprehensive evaluation. (Colby, J. *et al: J Am Coll Cardiol* 2:21-9 July 1983)

The effects of sucrose intake on diabetes were evaluated in another study. Thirty two patients in all, 12 with type I diabetes, 10 with type II diabetes, and ten healthy non-diabetics, had meals with sucrose. The diabetic patients continued with their usual insulin dosages. The post-prandial blood glucose level showed no greater hyperglycemia with sucrose than with other carbohydrates, such as potatoes, wheat, or glucose. (Bantle, J.: *N Engl J Med* 309:7-12 July 1983)

Autopsies in 100 randomly selected cases showed that advances in medical technology did not significantly alter the need for post-mortem examinations. The most often missed cases were systemic bacterial, viral and fungal infections. In 24% of the cases these clinical entities were missed entirely possibly because of the overreliance on radionuclide scans, ultrasound, and computerized tomography. (Goldman, L. *et al: N Engl J Med* 308:1000-5 1983)

The incidence of cancer in 6424 union members in the San Francisco area tumor registry were correlated as to work environments. Increased cancer incidence was noted for asbestos workers as well as painters in the respiratory tract-trachea, bronchus, lung and pleura. (Whorton, M.: *J.O.M.* 25:657-660, 1983)

Nearly all men over 55 have some degree of benign prostatic hypertrophy but no more than one per 100 have cancer. Some patients with known prostatic cancers exhibited colorimetric or enzymatic assays of normal acid phosphatase and some patients with small infarcts in the prostate without cancer exhibited elevations in this phosphatase because the acid phosphatase can ooze out of ischemic prostate cells. The only reliable means to detect prostatic cancer is the thorough examination of a competent physician. (Gittes, R.: *N Engl J Med* 309:14, 852-3 Oct. 1983)

The presenting symptoms of 167 patients with known carcinoma of the rectum, sigmoid and rectosigmoid were retrospectively reviewed. The earliest symptoms were changes in bowel habits and blood in the stool, followed by abdominal pain (32%) and weight loss (19%). Thirty-six percent of the short term survivors and 46% of the long term survivors experienced symptoms two months or less before diagnosis. The duration of symptoms were not critical in the survival duration. (Kumar P., Good, R., *J National Med Ass.* 75, 12:1147-9 1983)

A prospective study in 10 pregnant women who had relief of rheumatoid arthritis symptoms showed a significant elevation of their mean alpha-2-glycoprotein levels. Four pregnant women with rheumatoid arthritis who were not improved showed no elevation in their alpha-2-glycoprotein. These two groups were matched for age, duration of illness, pre-pregnancy disease activity, and pre-pregnancy drug therapy. (Unger, A. *et al: Br. Med. J.* 286:750-2, 1983)

The pain perception in 86 women with metastatic breast cancer was evaluated as to severity. In 48 cases with regular pain this was weakly associated with metastases to the bones and viscera and strongly tied to mood disturbances, social or family support, social functioning and coping strategies. Therapy thus should be directed to analgesics and emotional problems. (Spiegel, D., Bloom, J.: *Cancer* 52:341-5 1983)

Low intake and blood levels of riboflavin, folate, vitamin B-12, and ascorbate in the elderly may account for poor performance on cognitive tests. Riboflavin and vitamin C were positively correlated with verbal memory. Poor cognitive status may contribute to poor nutritional status. (Goodwin, J. *et al: JAMA* 249:2917-21 June, 1983) ◀

Viewbox

(Continued from page 153)

Diagnosis: Carcinoid Tumor of Small Bowel.

All choices given can cause diffuse or focal small bowel abnormalities which may look similar on barium studies. (Distinguishing features will be discussed later). This patient has mucosal lesions of several ileal loops which produce a nodular appearance and, in addition, the loops are spread apart indicating thickening of the bowel wall. The relatively long history of episodic diarrhea and abdominal pain is in keeping with a carcinoid. The symptom of episodic wheezing is another feature of the carcinoid syndrome and makes ileal carcinoid with liver metastases the best diagnosis.

Crohn's Disease (Figure 2)

Crohn's disease usually presents between ages 15-35 but may present in older patients. Any portion of the alimentary tract may be involved but the terminal ileum and colon are the most common sites. The proximal bowel is seldom involved without accompanying terminal ileum involvement. The severity of the disease is variable, and there is a wide range of radiographic findings.[1] The earliest findings are tiny aphthous ulcers. Mucosal ulcerations and thickening of mucosal folds may be the only finding of early non-stenotic disease. Narrowed segments of bowel separated by "skip" areas of uninvolved intestine are the classical findings.[2] The involved bowel loops may be separated from others by thickening of the intestinal wall or mesentery. Enteric fistulas or sinus tracts are frequently seen in this disorder and may communicate with other bowel loops, intra-abdominal organs, and the skin. Long sinus tracts are suggestive of Crohn's disease but can also be found in diverticulitis and perforated colon carcinomas.

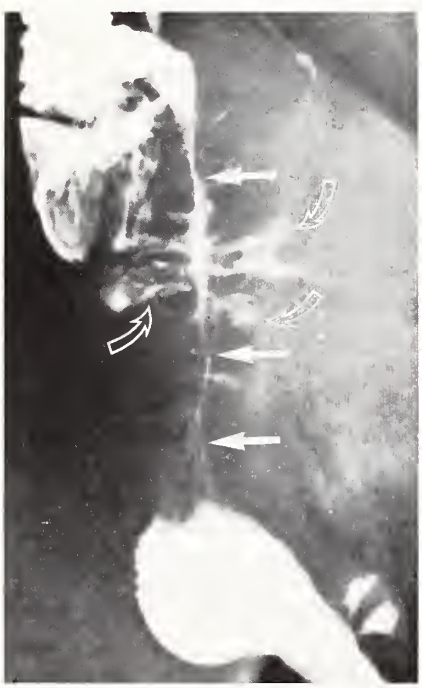


Figure 2
Crohn's Disease. The terminal ileum (solid arrows) is markedly narrowed. There are multiple sinus tracts (open arrows) characteristic of Crohn's disease.

Abdominal Carcinomatosis (Figure 3)

Carcinomatosis is another entity which can produce small bowel abnormalities on barium study. Tumor implantation can produce nodular filling defects. Sharp angulation of small bowel loops and stretching of mucosal folds along with fixation of intestinal loops are secondary signs of tumor implants. Ascites commonly accompanies carcinomatosis causing separation of centralized bowel loops, increased density of the abdomen, and loss of the liver angle.[2]

Figure 3
Abdominal Carcinomatosis. There are multiple abnormal loops with angulation (white arrow) and stretched folds in segment between black arrows. Note displacement of loops.



Peritoneal Mesothelioma (Figure 4)

Peritoneal mesothelioma, which is becoming more common, is another neoplastic process which can cause small bowel abnormalities. Bowel loops are often spread apart because of ascites. Extrinsic compression and constriction of intestinal loops may occur and incomplete obstruction may



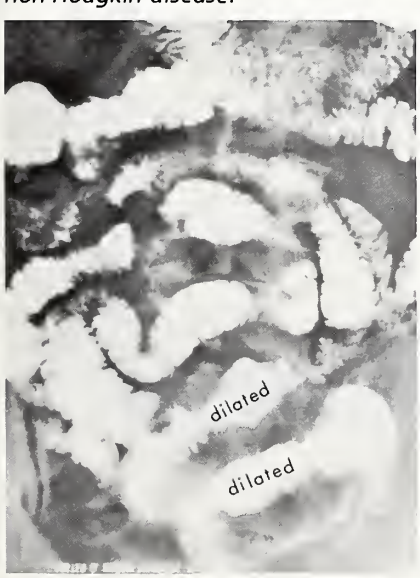
Figure 4
Peritoneal Mesothelioma. Note angulated loops converging to a point (small arrows) and stretched folds (large arrow). Postoperative adhesions, carcinomatosis, and carcinoid may cause similar changes.

produce dilation of proximal bowel. The intestinal mucosa may be stretched or ulcerated over infiltrating lesions. Angulation of bowel loops may be seen due to fixation by tumor (Figure 4).[2] The findings are often indistinguishable from abdominal carcinomatosis. The pathologic diagnosis may also be difficult. A history of asbestos exposure or evidence of pulmonary asbestosis are quite helpful.

Lymphoma (Figure 5)

Lymphomatous involvement of the small bowel can produce a wide variety of radiographic appearances. The process may be primary in the bowel or metastatic. Solitary or multiple filling defects may be seen. Separation of intestinal loops indicates a thickened bowel wall due to infiltrating tumor. Tumor infiltration can cause thickened mucosal folds or obliteration of folds. A widened bowel lumen, so called aneurysmal dilation, is very suggestive of non-Hodgkin's lymphoma (Figure 5).

Figure 5
Non-Hodgkin Lymphoma. Note dilated loops of ileum with loss of mucosal folds. The lack of obstruction despite extensive lesions combined with a widened lumen is characteristic of non-Hodgkin disease.



Carcinoid (Figure 6)

The carcinoid is the most frequent primary tumor of the small intestine.[3] The occurrence of carcinoid is greatest in the 4th and 5th decades of life and equal in men and women.[4] National Cancer Institute statistics show the greatest occurrence to be in the appendix (41%) followed by small intestine (21%) and rectum (14%). In the small intestine the majority of lesions occur in the ileum.[4] Bronchial carcinoids are the most common extra-gastrointestinal tumors, making up 12% of the total.[4]

Symptoms are often chronic and include gastrointestinal bleeding with resultant anemia, diarrhea, cramping abdominal pain and intussusception.[4,5] Carcinoid syndrome occurs in about 5% of patients and virtually always in patients with liver metastases.[4] The symptom complex may include flushing, episodic diarrhea, asthma like episodes, tachycardia, and right sided heart failure due to endocardial fibrosis.[6] The syndrome is due to serotonin and other pharmacologically active substances including kinins, prostaglandins and gastrointestinal hormones.

Carcinoids can metastasize, most frequently involving regional lymph nodes and liver. Lung, bone and brain may also be involved by metastasis but much less commonly. Malignant potential in these tumors has been related to location of the primary, tumor size, invasion of the bowel wall and multicentricity. Carcinoids of the colon (70%) and ileum (34%) have the highest incidence of metastases while only 2-5% of appendiceal lesions metastasize. Carcinoids greater than 1cm in size

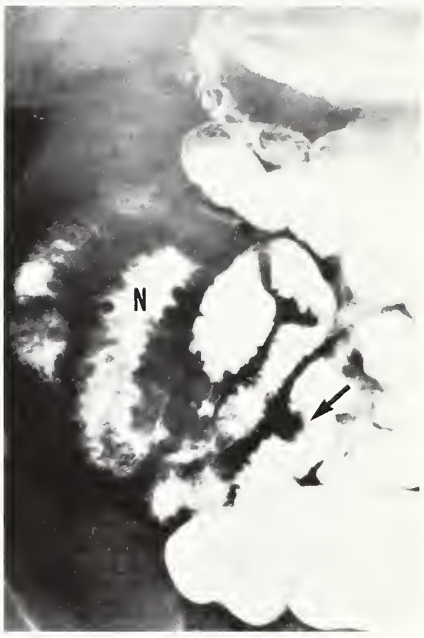


Figure 6
Ileal Carcinoid. The abnormal loops are spread apart indicating thickening of bowel wall or mesentery. Note multiple nodules in one bowel loop (N) and a nodular filling defect (arrow) in an adjacent loop.

have a higher incidence of metastasis (29%) than those less than 1cm (6%).[4] Primary lesions which penetrate the serosa or are multicentric also have a higher incidence of metastasis.[5]

Diagnosis of small bowel carcinoids is often delayed due to the non-specific nature of symptoms. The mean duration of symptoms has been reported to be as long as 4 years before diagnosis. A barium small bowel series is the most valuable preoperative study.[7] The radiographic finding in an early lesion is a well circumscribed submucosal nodule occasionally with overlying mucosal ulceration. On angiography, carcinoid tumors demonstrate a tumor blush at the primary site which may be enhanced by the administration of epinepherine.[3] The vasculature surrounding the

tumor may be kinked and the distal mesenteric arcades narrowed. In some lesions there is a spoke wheel arrangement of vessels. Liver metastases are hypervascular.[8]

Treatment of carcinoid is surgical, even in patients with metastatic involvement, due to the slow growth of the tumor. Lesions less than 1cm in diameter require only segmental resection. If the tumor is greater than 2cm, an adequate resection with removal of regional nodes is required. In patients with metastatic disease, 5-flouro uracil has been used to treat carcinoid syndrome.[5]

Prognosis in patients with carcinoid is dependent on the site of the primary and extent of metastatic involvement. Primary appendiceal involvement gives the best prognosis, 99% five year survival. Lesions of the stomach, small intestine and colon have a much worse prognosis with about 50% of the patients surviving 5 years.[4] In one series including all primary sites, 95% of patients without metastasis survived for 5 years. Involvement of local lymph nodes decreased 5 year survival to 83% and distant metastasis to 38%. The cause of death in many patients with carcinoid is a second primary, the most common being adenocarcinoma of the colon.[4] ◀

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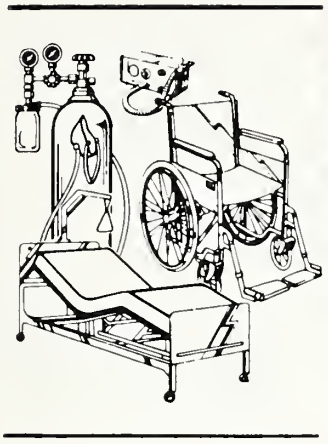
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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

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Planning

By Susanne Webb, ISMSA President

Planning is generally divided into two parts: long range (five years) and short range (one or possibly two years). The purpose of planning is the achievement of purposes or goals. The goals of the auxiliary as stated by our bylaws are:

1. To assist the Illinois State Medical Society in its program to improve the quality of life through health education and services
2. To advise and to coordinate the activities of county auxiliaries
3. To encourage the participation of volunteers in activities that meet health needs
4. To cultivate friendly relationships and promote mutual understanding among physicians' families.

These goals should be reviewed regularly and revised when necessary. This is the responsibility of the Long-Range Planning Committee:

1. To evaluate auxiliary programs and procedures, taking into consideration present and future growth of the auxiliary.
2. To endeavor to focus on future objectives and make recommendations to stimulate decisions which would contribute to the growth of the auxiliary.
3. To be aware of the resources of the auxiliary when making recommendations.

This is accomplished by developing long range goals and implementing them through short range goals.

Goals are formed by evaluating existing goals and purposes, considering new goals or purposes to pursue in future and ranking goals in terms of anticipated importance.

In ranking goals one needs to consider who benefits, the human and financial costs, the importance to the organization's survival and the probability of attainment. Those goals rank highest that have the greatest importance to the largest segment of the membership and the greatest possibility of achievement.

Goals are implemented through objectives which are set by asking where, how, why and by whom it should be done.

The answers to these questions will guide us in setting valid and realistic goals for our organization. The leadership at all levels always welcomes suggestions for the planning process. ◀

MEDICAL DIRECTOR

A 401 bed progressive, not-for-profit community hospital, 15 minutes from St. Louis, is seeking to replace retiring Medical Director of 12 years. Individual will function in an administrative capacity on a full time basis (private practice not permitted). The Medical Director serves as liaison between the Medical Staff, Administration, and the Board of Directors, and attends Medical Staff and Administrative meetings. This position reports to the President of the Board of Directors. Candidates must have good communication skills, ability to work with all types of people, and be familiar with medical staff bylaws, quality assurance, JCAH, DRG's, CME, etc.

Send CV and salary requirements in confidence to: Taylor O. Braswell, President, Memorial Hospital, 4501 North Park Drive, Belleville, Illinois 62223. Telephone (618)233-7750.

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

April 1	Hinsdale Sanitarium & Hospital & ACS	*Hinsdale*
April 3	Illinois Interagency Council on Smoking & Disease	*Chicago*
May 1	Northwestern Memorial Hospital	*Chicago*
May 1	Illinois Interagency Council on Smoking & Disease	*Chicago*
May 1	Skokie Valley Health Dept.	*Skokie*



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DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Joseph B. Kirsner, M.D., Chicago, will receive the John Phillips Memorial Award for his contributions to internal medicine at the American College of Physicians 65th annual session in Atlanta, April 26-29.

Officers recently elected to the St. Clair County Medical Society are: **Robert C. Wanless, M.D.,** Edwardsville, president; **Terrence G. Klingele, M.D.,** president-elect; **Edward P. Rose, M.D.,** vice president; **Robert E. Schultz, M.D.,** secretary; and **Silvana Menendez, M.D.,** treasurer, all of Belleville.

The Livingston County Medical Society recently installed the following officers: **H. C. Parkhill, M.D.,** Pontiac, president and delegate to ISMS; **George Chen, M.D.,** Chatsworth, vice president and alternate delegate to ISMS and **Karl Deterding, M.D.,** secretary/treasurer.

Newly elected Will-Grundy officers are: **Jon F. Nicosia, M.D.,** president; **Theodore Dastych, M.D.,** vice president; **Theodore Kanellakes, M.D.,** president-elect and **Morton Barnett, M.D.,** secretary-treasurer, all of Joliet.

Edward C. Farkas, M.D., Danville, was recently elected as president of the Vermilion County Medical Society.

Joseph Nora, M.D., Chicago, received a Mother Cabrini Award at a recent Columbus-Cuneo-Cabrini Medical Center dinner.

Richard S. Wilbur, M.D., Lake Forest, has been named chairman of the board of directors of Medic Alert Foundation International.

Shirley B. Lansky, M.D., Chicago, was recently appointed director of the Illinois Cancer Council Comprehensive Cancer Center.

Delmar Balquiedra, M.D., Chicago, has been elected president of St. Anthony Hospital Medical and Dental Staff.

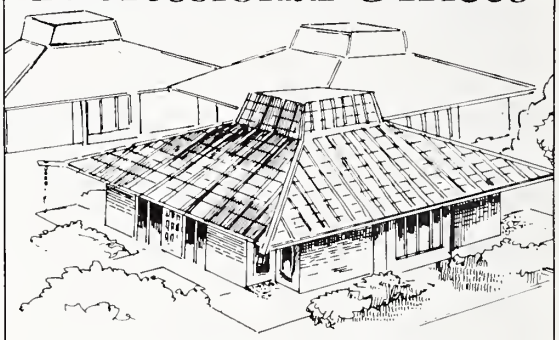
Domeena C. Renshaw, M.D., Lombard, has been appointed to the editorial board of the *Journal of the American Medical Association.*

HEALTH REPORTING/RADIO-TV CONFERENCE

Physicians and reporters are invited to attend the 1984 Health Reporting/Radio-TV Conference, May 3-6, in Washington, D.C. This four day conference, sponsored by the American Medical Association's Department of Radio, TV and Motion Picture Services, will consist of courses on medical reporting and broadcasting. Registration fee is $275 for AMA members, $375 for non-members and $75 for students/residents. For more information contact the American Medical Association, 535 N. Dearborn, Chicago, IL 60610.

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Better Utilization of Medical Assistants Can Increase Office Efficiency.

By Janet M. Hensinger, CMA-A

Physicians and medical assistants are working together toward a common goal—to provide the best possible medical care to the patients they serve in the most efficient and cost effective manner. To accomplish this goal requires skill, technique, caring, and dedication on the part of all members of the team in the medical office.

In an office based medical practice, it is essential that the talents and skills of all staff members be utilized to the fullest. The efforts of the entire office can be impeded by the office manager or physician who does not utilize fully the talents of the medical assistants. When an office decides to offer new services or change a procedure, it is often the easier road to bring in a new employee to take on these duties than to reassign duties and responsibilities to present staff members.

Medical assistants are professional, multiskilled persons who many times are not allowed or encouraged to assume new responsibilities in the office. When this happens, everybody loses . . . physician, medical assistant and patient. The hiring of an additional staff member adds greatly to the overhead expense of the office. Personnel expenses (salary, benefits, taxes) are one of the top expense categories in any office. Many times an office may have to increase its fees in order to meet the additional expense of an added employee.

The medical assistant who becomes pigeon-holed into one job with no change of responsibilities year after year may become bored and dissatisfied. Employees who become bored with their duties will perform at less than maximum levels and will soon begin to look for "greener pastures." Employees who are interested in what they are doing and who feel they are a valuable part of the overall efforts of the office will perform at top efficiency.

Proper and full utilization of the skills of the medical assistants in the office can increase productivity in the office, help hold down office expenses and improve morale of the entire staff. When new services or procedures are to be incorporated the medical assistants already on staff can be often taught the necessary skills to assume these new duties.

When our office incorporated, our accountant suggested that we begin to perform more of the accounting tasks in the office. The office paid the fee for a medical assistant to take a one semester accounting course at a local college. Now, the medical assistant produces the monthly income and expense statements as well as all quarterly and annual employee tax reports. With the accountant now only preparing the year end corporation tax return, this annual fee has been cut in half. This resulted in a nice savings.

The next time you decide to change some procedures in your office, look around at your existing staff of medical assistants. By training your present staff to handle increased responsibilities, you will take a large step toward our common goal of providing the best possible medical care in the most efficient and effective manner.

Information regarding the Illinois Society, AAMA, may be obtained from Betty Kronemeyer, CMA, president, Illinois Society, 809 North 10th Street, Mascoutah, IL., 62258, or Lesa B. Greene, CMA-C, chairman, Public Relations Committee, 8836 West Grand Avenue, River Grove, IL., 60171. ◀

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510 Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MARCH

Practice Management

Choosing & Using a Computer in Private Medical Practice
For: MD's. Lecture, March 23-24, 8am-5pm, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215

Family Medicine

Medical Seminar-At-Sea
For: MD's. Seminar, March 15-25, Caribbean Sea. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 36 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711

Pathology

Hormonal Pathology of the Endometrium
For: Pathologists & Clinical Chemists. Symposium, March 19, 7pm, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, M.D., S.C. **Phone:** 312-626-4300, Ext. 5720

Licensure

State & National Board Review, Basic
For: MD's Taking State Licensure Exams. Lecture, March 19-25, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** 90. **Credit:** Category 1, 62 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

State & National Board Review, Clinical
For: MD's Taking State Licensure Exams. Lecture, March 26-31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** 90. **Credit:** Category 1, 56 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Dermatology

Pediatric Dermatology
For: MD's. Lecture, March 19-21, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $280. **Reg. Limit:** 55. **Credit:** Category 1, 21 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Ophthalmology

8th Annual Ophthalmology Current Concepts Seminar '84
For: Ophthalmologists, RN's. Conference with Workshops, March 22-24, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credits:** Category 1, TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

APRIL

Surgery

Advanced Trauma Life Support Course
For: MD's, Office Staff. Workshop, Dates TBA, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, TBA. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Flexible Fiberoptic Sigmoidoscopy
For: MD's. Lecture, April 14, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $125. **Reg. Limit:** 75. **Credit:** Category 1, 7 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Advanced Peripheral Vascular Surgery
For: MD's. Lecture, April 16-20, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390. **Reg. Limit:** 90. **Credit:** Category 1, 34 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Surgery Visiting Professor Lecture Series
For: MD's. Lecture, April 18, 8am-5pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215

Fiberoptic Colonoscopy
For: MD's. Lecture, April 25-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Surgery

Fiberoptic Esophagogastric Endoscopy
For: MD's. Lecture, April 30-May 2, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Psychiatric Medicine

Anxiety and Medical Illness
For: MD's, Office Staff. Symposium, Dates TBA, Jacksonville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Electroconvulsive Therapy—1984 Update
For: MD's, RN's, Mental Health Prof. Conference, April 6-7, Sheraton Inn, Madison, Wisconsin. **Sponsor:** Center for Affective Disorders, Dept. of Psychiatry, 600 Highland Ave., B6/255, Madison, Wisconsin 53575. **Fee:** $200 MD's, RN's, Mental Health Prof.; $100 Res. & Trainees. **Reg. Limit:** 200. **Credit:** Category 1, 10 hours, UW-Extension CEU's, 1.0. **Contact:** Dorothy B. Davidson, Ph.D. **Phone:** 608-263-6129

Radiology

Specialty Review in Radiology
For: Radiologists. Lecture, April 2-6, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** None. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Radiology

For: MD's, Office Staff. Symposium, April 5, Lincoln, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 5 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Urology

For: Urologists. Lecture, April 2-7, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** None. **Credit:** Category 1, 53 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Pathology

Selected Topics in Surgical Pathology
For: Pathologists & MD's. Lecture, April 2-6, 8am-5pm, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison, Chicago 60612. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 32 hours. **Contact:** Linda Mays. **Phone:** 312-738-1336

Cytology of Conduloma & Cervical Intraepithelial Neoplasia
For: Pathologists & Clinical Chemists. Symposium, April 9, 7pm, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central, Chicago 60644. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, M.D. **Phone:** 312-626-4300, Ext. 5720

The Myeloproliferative Disorders: A Multidisciplinary Approach
For: Pathologists. Lecture, April 23-27, 8am-5pm., Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison, Chicago 60612. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 33.5 hours. **Contact:** Linda Mays. **Phone:** 312-738-1336

Specialty Review in Pathology: Anatomic
For: Pathologists. Lecture, April 23-28, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480. **Reg. Limit:** 90. **Credit:** Category 1, 48 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Specialty Review in Pathology: Clinical
For: Pathologists. Lecture, April 30-May 4, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 90. **Credit:** Category 1, 41 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Family Medicine

Cancer Symposium for Clinicians
For: MD's. Symposium, April 7, Jumer's Conference Center, Urbana, Illinois. **Sponsor:** Illinois Cancer Council, 36 South Wabash, Ste. 700, Chicago 60603. **Fee:** $50 MD's; $25 RN's; $15 Res. **Reg. Limit:** 125. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Arlene N. Alexander, M.D. **Phone:** 312-346-9813

Cardiac Rehabilitation

Cardiac Rehabilitation Workshop
For: MD's, Health Care Prof. Workshop, April 9-13, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Mitchell Hall, University of Wisconsin-La Crosse, LaCrosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

Emergency Medicine

Emergency Medicine for the Acutely Injured Patient
For: MD's, Office Staff. Symposium, April 10, 7pm-10pm, Vandalia, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Gynecology, Oncology

Current Management of Problems on Gynecology and Gynecologic Oncology
For: Gynecologists, Oncologists. Course, April 13-14, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago 60637. **Fee:** $195 MD's; $100 Res. **Reg. Limit:** None. **Credit:** Category 1, 9 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Endocrinology

Clinical Endocrinology Conference
For: Endocrinologists. Course, April 14, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago 60637. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 7 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Oncology

Advances in Breast, Genitourinary, & Esophageal Cancer Therapy
For: MD's. Course, April 18, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago 60637. **Fee:** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 6.5 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

OB/GYN

11th Annual Symposium on Obstetrics and Gynecology
For: MD's. Symposium, April 26-27, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, CME Office, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $200. **Reg. Limit:** 150. **Credit:** AMA Category 1, 13 hours; AAFP Prescribed, 13 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Rehabilitation

10th National Conference on Case Resolutions of Complex Industrially Injured
For: MD's, Therapists. Conference, April 26-27, Paper Valley Hotel, Appleton, Wisconsin. **Sponsor:** University of Wisconsin-Extention, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; UW-Extention CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Anesthesiology

Specialty Review in Anesthesiology
For: Anesthesiologists. Lecture, April 29-May 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $590. **Reg. Limit:** None. **Credit:** Category 1, 54 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

MAY

Cardiac Rehabilitation

7th Annual Symposium: Cardiac Rehabilitation—Update 1984
For: MD's, Nurses, Therapists, Allied Health Prof. Symposium, May 1-4, Milwaukee, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 28 hours; UW-Extension CEU's, 28. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Neuroradiology

1984 Neuroradiology Review Course
For: Radiologists, Neuroradiologists, Neurosurgeons, Residents. Course, May 5-6, Oak Brook, Illinois. **Sponsor:** Loyola University Medical Center CME and Section of Neuroradiology, 2160 S. First Ave., Maywood 60153. **Fee:** $140 MD's; $80 Res. **Credit:** Category 1, 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** 312-531-3237

Medical Education

Teaching Clinical Competence
For: MD's. Workshop, May 7-8, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, TBA. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711

Diagnosis and Treatment of Clinical Performance Problems
For: MD's, Workshop, May 9-10, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, TBA. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711

Surgery

Advances in Surgery
For: General and Specializing Surgeons. Lecture, May 7-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $420. **Reg. Limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

The Development and Current Concepts of Gastrinoma Syndrome
For: MD's. Lecture, May 9, 2pm-4pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215.

An Overview of Surgical Oncology
For: General Surgeons. Symposium, May 9-11, Chicago. **Sponsor:** University of Illinois at Chicago, c/o Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $250 MD's; $150 Res. **Reg. Limit:** 300. **Credit:** Category 1, 19 hours. **Contact:** Lloyd M. Nyhus, M.D. **Phone:** 312-996-6765

Cardiology

For: MD's, Office Staff. Symposium, May 10, 1pm-5:15pm, Flora, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Pathology

Annual Slide Seminar: Problems in GI and Endoscopic Biopsies
For: Pathologists and Clinical Chemists. Symposium, May 14, 7pm, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, M.D., S.C. **Phone:** 312-626-4300, Ext. 5720

Morphologic Approach to Blood Disorders
For: Pathologists. Lecture, May 14-18, 8am-5pm, Chicago. **Sponsor:** American Society for Clinical Pathologists, 2100 W. Harrison, Chicago 60612. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, 32 hours. **Contact:** Linda Mays. **Phone:** 312-738-1336

OB/GYN

Specialty Review in Obstetrics and Gynecology
For: Obstetricians and Gynecologists. Lecture, May 14-19, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480. **Reg. Limit:** TBA. **Credit:** Category 1, 48 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Dysfunctional Uterine Bleeding and Evaluation and Treatment of Infertility
For: MD's, Office Staff. Symposium, May 24, 1pm-5:20pm, Pinckneyville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711

Radiology

Nuclear Magnetic Resonance, Computer Tomography, and Digital Radiography
For: Radiologists: Med. Physicists. Conference, May 15-18, Chicago. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** TBA **Credit:** Category 1, 25 hours, UW-Extension CEU's, 25. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Internal Medicine

11th Annual Internal Medicine Symposium
For: MD's, Office Staff. Symposium, May 17-18, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed: TBA. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Hemorrhagic Complications of Disease
For: MD's, RN's, Technologists. Conference, May 31-June 1, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $160 MD's; $125 Others. **Reg. Limit:** None. **Credit:** Category 1, 12 hours; UW-Extension CEU's, 12 hours; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Clinical Medicine

Computers and Clinical Medicine
For: MD's, Office Staff. Symposium, May 15, 7pm-10pm, Effingham, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $30. **Reg. Limit:** None. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Psychiatry

Comprehensive Psychiatry Review, Part II; The Psychiatric Interview
For: Psychiatrists. Course, May 18-20, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago 60637. **Fee:** $325. **Reg. Limit:** None. **Credit:** Category 1, 17 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Neurology

Stroke: Diagnosis, Prevention, Treatment
For: MD's. Lecture: May 19, 8am-1pm, Urbana, Illinois. **Sponsor:** Carle Foundation Hospital, Department of Medical Education, 611 W. Park St., Urbana 51801. **Fee:** $35. **Reg. Limit:** TBA. **Credit:** Category 1, 4.5 hours, AAFP Elective, 4.5. **Contact:** Deborah C. Rugg. **Phone:** 217-337-3022

Practice Management

Choosing and Using a Computer in Private Medical Practice
For: MD's. Lecture, May 25-26, 8am-5pm, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215

Family Medicine

Specialty Review in Family Practice
For: GP's, FP's. Lecture, May 29-June 9, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Reg. Limit:** 90. **Credit:** Category 1, 91 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MD's. Lecture, May 29, 4:30pm-6:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215

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Keeping An Eye On Big Brother



With the annual meeting of the ISMS House of Delegates, an old year ends and a new year begins for the Society. As your incoming president, I shall be your spokesman and will represent you as honestly, forcefully and effectively as I possibly can.

Nineteen eighty four—the year of George Orwell's Big Brother—is already one quarter spent. Although Orwell was frighteningly prescient, most of his dire predictions have not come to be. Still, parallels exist, and are among us.

Given the onset of Medicare in 1966, many thought that full socialization of medicine would be a fact years before now. Although we are closer to that point than we were, it has not yet come to be. Big Brother watches closely, but still from a distance.

We face many challenges at the present—the whole complex problem of malpractice and professional liability, the increasing cost of medical care and its containment, the availibility and distribution of good care to those who need it—to mention only a few. New and bigger problems will arise, as they always do, for it seems the greatest accomplishments of a term of office are generally those that did not exist at the onset.

Big Brother is still watching us, but we'll keep an eye on him, too.

Robert C. Hamilton, M.D.
President

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal*, however, will secure author permission before authorizing a reprint.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nitedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern ot angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PRDCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PRDCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PRDCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PRDCARDIA

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PRDCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nifedipine. PRDCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

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Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE—Take general measures as for any CNS depressant.

SUPPLIED—TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

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(clorazepate dipotassium Ⓒ)
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Please see brief summary on an adjacent page.

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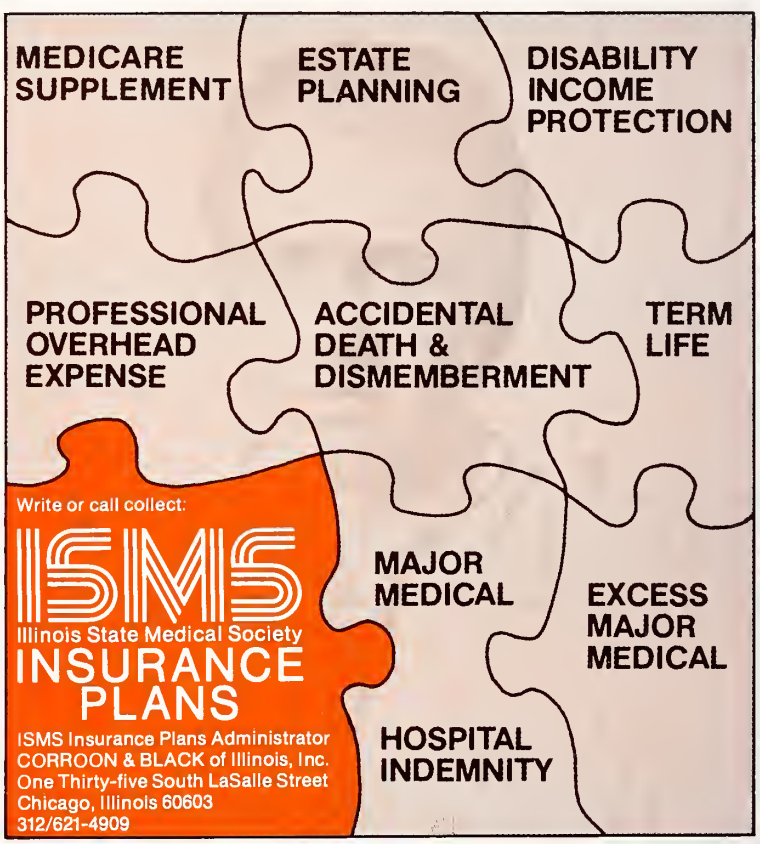
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Time and People Do March On

Dear Editor:

It is always difficult and depressing to witness a tragedy. I always leaven such uncomfortable experiences with the hope that it won't happen again, or if it does, preferably not to me or in areas near me. Tragedies are not quite as bad when they occur at a distance and with places or folk with which you have little association.

Fred and Emma Schwartz closed their confectionery and grocery on Saturday. No big deal in the overall scheme of events, but a real tragedy for me to realize that I will no longer be able to go in and select from the glass jars with the screw-on lids tipped at a 30° angle on their side and filled with different kinds of candies, bread sticks, and other nonessential but very attractive bits of edible merchandise. Emma was always good for gratuitous advice on the best produce and which loaf of bread was freshest. Advice on weather and grain futures was seldom right, but always and generously given. There were wire-backed chairs in the front surrounding a marble-topped table. One could sit there for as long as one liked with or without a Coke, with or without a straw.

Last March a big new building operated by one of the nationwide grocery chains opened on the north end of town with lots of parking spaces, fluorescent lights, and everything packaged, shelved and stacked. Nice, young, bright people were about, if you could find them, to help with the produce and grocery purchases. Unfortunately, their advice and comments were limited to "Look down that aisle, Sir" and "Have a nice day." Very little of substance, right or wrong.

There was nothing that could be purchased as single items like three gum drops or four wrapped caramels. If I want to buy anything, I have to buy a box or a bottle or a can of it. Certainly there are more items available, they can be had and taken out with a great deal more speed, and the choices are infinite. Unfortunately, they aren't my choices, but the choices of the grocery chain.

The tragedy in the making became apparent as people left Schwartz's Confectionery and Grocery and began to do their shopping in the low price, multi-choice, new supermarket. The Schwartzes tried to combat that by becoming part of an owner chain—The Confectioners Independent Association—which did bring them merchandise at a more favorable wholesale cost, and they could bring their retail prices down approaching those of the supermarket. Unfortunately, this CIA activity came too late, and the trend had already begun and snowballed toward the supermarket. On Saturday, Schwartz's Confectionery and Grocery closed.

It seems to me that even in Mt. Hawley people are beginning to put cost and convenience ahead of personal service, craftsmanship, warmth and comfort. A handmade piece of furniture is expensive and treasured but not nearly as many of these are purchased as are the chrome and vinyl mass-produced chairs and tables. Mom and Pop stores fade before the franchised stores which fade before the supermarkets. Mass production with more sameness of the product, less personality, and lower cost, is seemingly becoming a priority here at Mt. Hawley as well as in the broader national scene.

On Monday at the Apollo, Old Doctor Frank was talking about all of those competitive things in medicine that you folk in the *Journal* refer to frequently. Doc is sure that his patients will continue to want his warm, friendly attitude and caring philosophy in preference to any of those HMO's or PPO's that may crop up in big cities like Evansville or St. Louis. His patient population is loyal, he says and he takes good care of them. I cited the progression I noted from Mom and Pop to investor-owned large groups like IGA and then on to the megasupermarkets as a progression that could occur from individual or group practice to a network of investor-owned offices, as in IPA to an HMO. I pointed out that the investor groups that have worked got there early and competed and were successful whereas those that didn't get there early were not. Doc is sure that his patients are loyal and will stay with him.

I do hope Doc is right. Witnessing one tragedy is quite enough for me in this town at this time. Time and people do march on. ◂

Sincerely Ys.
E. Goodwins



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By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

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START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

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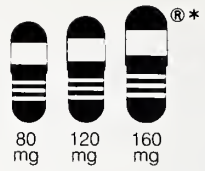


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ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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Ayerst AYERST LABORATORIES
New York, N.Y. 10017

MEMBERSHIP FORUM

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Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

Factors Affecting Fees and Services

To the Editor:

In order to assess what internal and external factors are of particular importance in the medical fee for services system, we recently studied the medical marketplace in Wayne and Edwards Counties in Illinois. For the purpose of the study, the sample was defined as those providers of all types of patient care, licensed to practice independently. Ninety four percent (15) of the professionals in these counties participated by completing a questionnaire. The respondents consisted of physicians (DO or MD) and non-physicians (chiropractors, dentists, optometrists, and a psychologist).

The data was compared by physician and non-physician for: 1) factors of influence on their practice; (2) factors that influenced their fees and 3) factors that determined the services provided. With respect to the practice in general, it was very interesting that both physicians and non-physicians gave exactly the same rank order for the six factors: patient satisfaction, personal preference, the community, the economy, peer review and government in that order. Also, all respondents recognized that their practices were affected by multiple influences. In other words, the provider could not focus the practice completely on the needs of just patients, or self, or community, or peer, or government. But the very low ranking given to government's influence suggested a lack of appreciation for the importance of government. (It is a fact that all providers adhere to federal, state, and county legislative and judicial standards in every phase of their operations.)

With respect to specific factors influencing the fees charged, competition (fees charged by other professionals) was by far the most important single influence on respondent fees. This factor was followed by respondent's expertise, patient's ability to pay and income production. Income production and the economy were seen as moderate influences by both physicians and non-physicians. However, physicians saw their reputations and the way they felt at time of service to also be of moderate importance. The physicians perceived no factor affecting fees as of little importance, in other words, they could not appreciate significant difference in the effect of factors other than competition or their expertise.

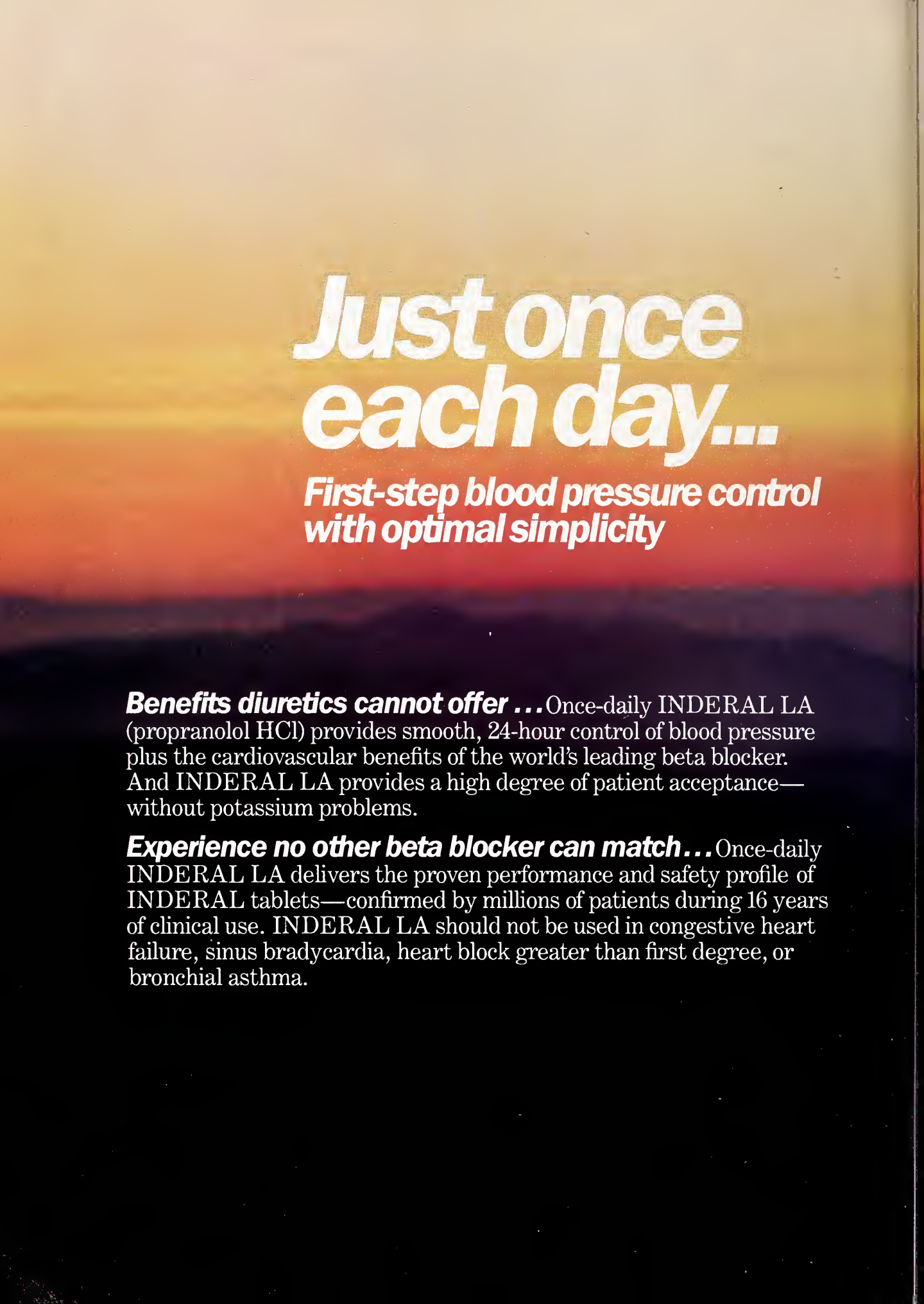
Respondents in the sample ranked patient needs first, personal skills second, and technology third as influences on their service offerings. The perceived difference between the third factor and the remainder of factors was large. Both groups saw malpractice risk and government regulation as of little influence. It was particularly interesting that the respondents did not perceive competition (services other professionals provide) as a more important influence on services when competition was the most important factor influencing fees. There were differences in the way physicians and non-physicians perceived the factors of influence on services. Physicians ranked personal skills first, technology and then patient needs in that order. Non-physicians ranked patient needs first followed by personal skills and technology.

Further study is needed to verify and extend these findings. As our study population was too small for statistical analysis, a larger sample should be studied over a wider area incorporating more types of practitioners and practice settings. Checks need to be made of how provider attitudes toward fees and service vary with the level of the doctor's income and number of years in practice. Once providers, consumers, and third parties become aware of the types of influence and the nature of their impact, it becomes possible to make beneficial interventions in the fee for service system without risk of side effects and to more nearly fit the needs of the society. A more sound adjustment to the market environment can lead to better medical care with decreased cost.

Sincerely,
Vera C. Loftin, M.B.A.
Fairfield, Illinois

Eugene B. Loftin, III, M.D.
Fairfield, Illinois

C. Glenn Walters, PhD
Professor of Marketing
Southern Illinois University
Carbondale, Illinois


Just once each day...
First-step blood pressure control with optimal simplicity
Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.
Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Just once each day for initial therapy in hypertension.

Ayerst®

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL™ LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

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Pediatric Use: Safety and effectiveness in children have not been established.

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If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

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PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

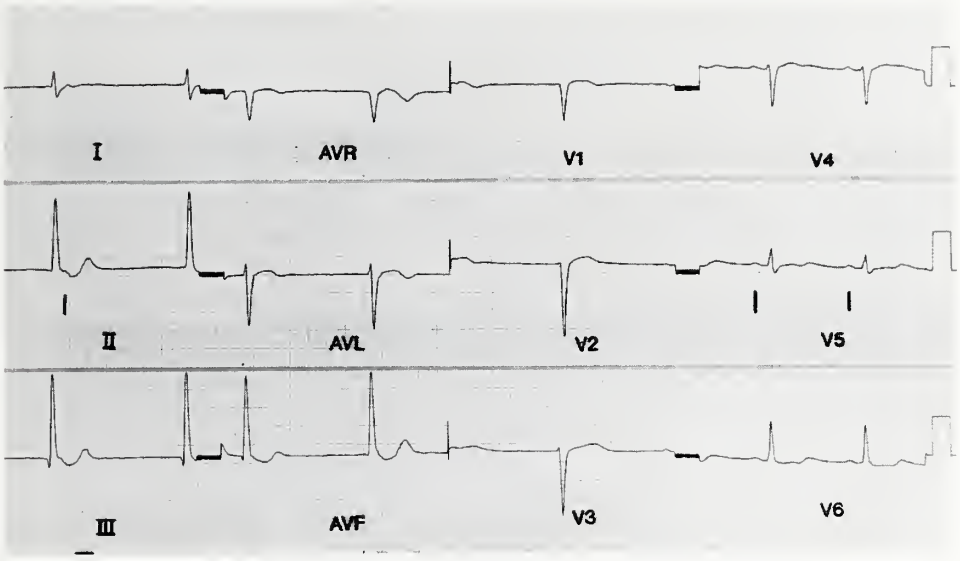
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Ayerst AYERST LABORATORIES
New York, N.Y. 10017

EKG OF THE MONTH

CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



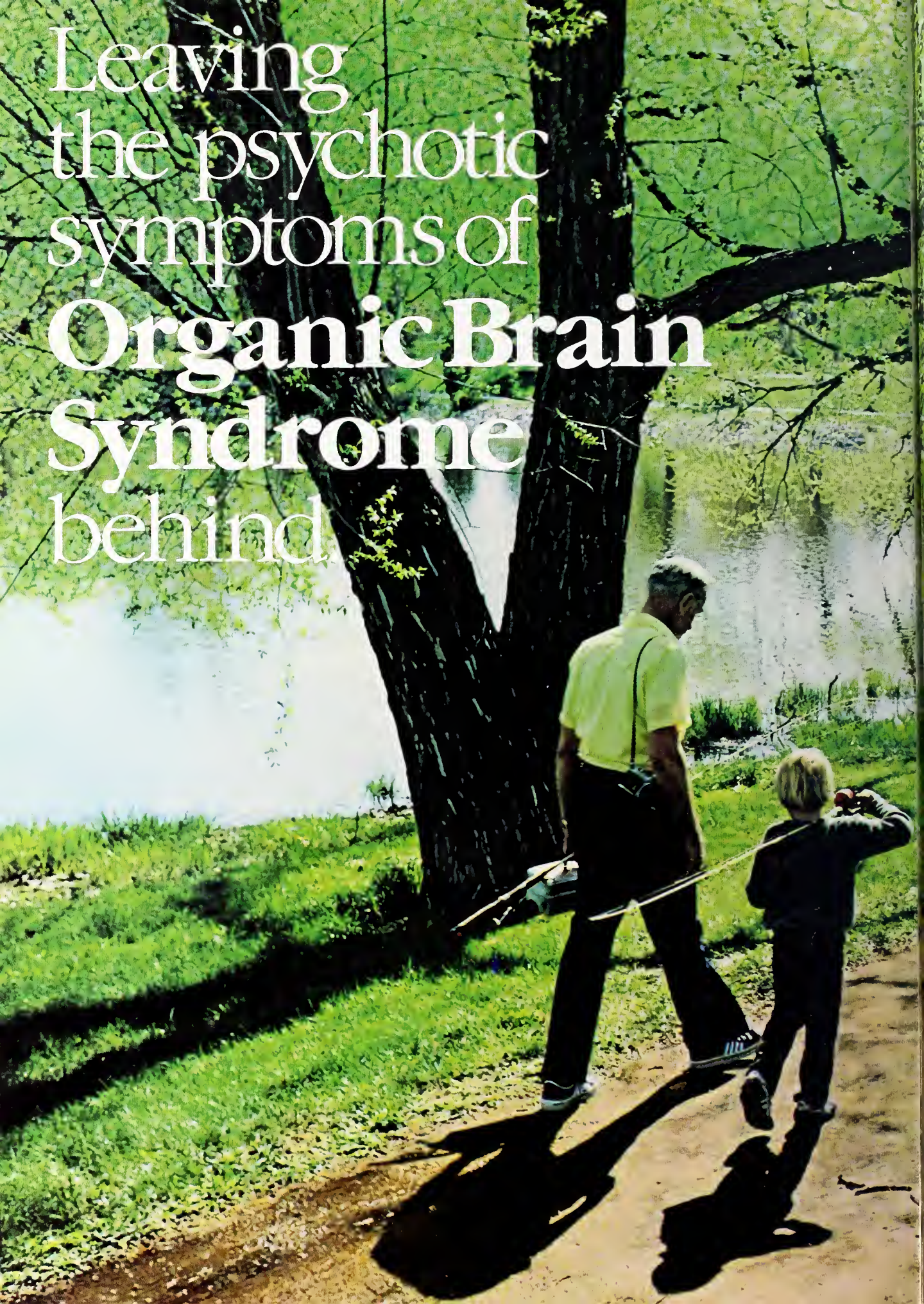
This is a seventy-four year old man who gave a two week history of chest pain and palpitations. The chest pain was located in the retrosternal area of the chest and radiated to his neck. Although the pain occurred during the day when he walked too fast, the worst pain occurred at night and would awaken him from a sound sleep. In the office a chest pain was relieved by a sublingual nitroglycerin tablet. The palpitations were described as a slow, heavy beating of the heart. These heart beats were not always associated with the chest pains. He also complained of some dyspnea on exertion but this was unchanged for the past year. He had taken digoxin for the past year because of the onset of atrial flutter at that time. Prazosin had been added for moderate hypertension about six months before. About a month before this visit, quinidine had also been added to his treatment. Physical examination showed a blood pressure of 118/68mmHg, bibasilar crepitant rales, and a pulse rate of fifty beats per minute. His twelve lead ECG is shown.

Questions:

1. The ECG shows:
 - A. Left ventricular hypertrophy.
 - B. Intermittent left bundle branch block.
 - C. Intermittent atrioventricular dissociation.
 - D. Sinus node block or sinus arrest.
 - E. Junctional rhythm.

2. The following statements is/are true:
 - A. This bradycardia could be part of the bradycardia tachycardia syndrome or the sick sinus syndrome.
 - B. This arrhythmia could be a result of digitalis excess or toxicity.
 - C. A digoxin-quinidine interaction ought to be considered.
 - D. This patient has unstable angina pectoris.
 - E. All of the above.

(Continued on page 288)


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

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ROERIG Pfizer
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

Navane®
(thiothixene) (thiothixene HCl)

References. 1. Util TM, Unverdi C, Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM. Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58 87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM: Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14 775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml

Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.

Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects. Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

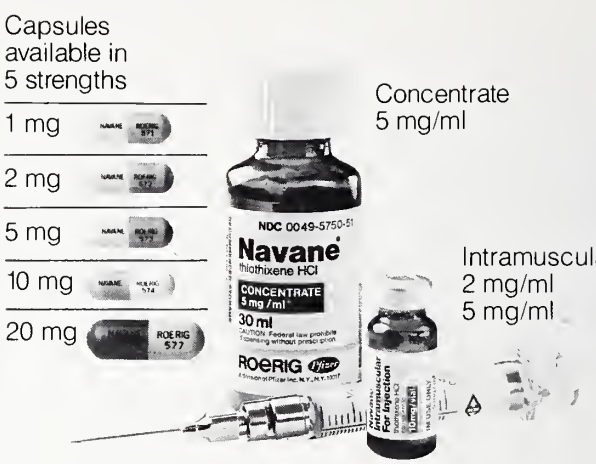
CNS effects. Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia. As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia, antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules; Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

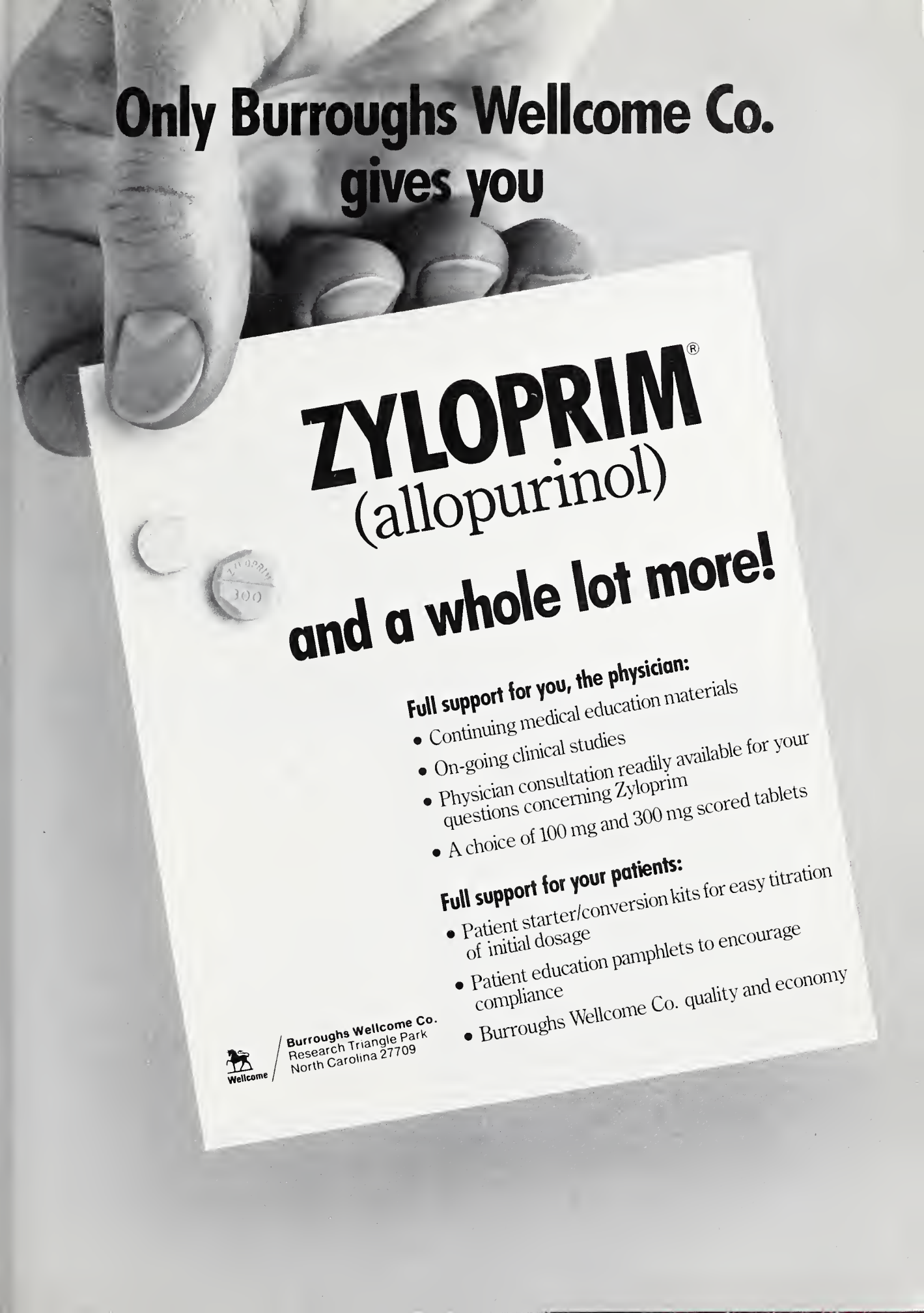
Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

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A Delicate Balance

ISMS Guide To Hospital Medical Staff Bylaws

At its September, 1983, meeting, the ISMS Board of Trustees approved and mandated publication of the "ISMS Guide to Hospital Medical Staff Bylaws."

This document was developed by the Ad Hoc Committee on Resolution 37 (A-81), a subcommittee of the Council on Medical Services. Members of that subcommittee, chaired by Wallace Berkowitz, M.D., were James R. DeBord, M.D., C. Larkin Flanagan, M.D., Allan L. Goslin, M.D., A. Beaumont Johnson, M.D., Donal D. O'Sullivan, M.D. and David Whitney, M.D.

It is hoped that this guide will help physicians to balance the many complex issues confronting hospital medical staff members. As demonstrated at the November, 1983, ISMS Leadership Conference, today's physician must juggle many roles. This guide is intended to assist the physician who seeks to meet his responsibilities and exercise his rights in the professional context.

This feature is the first in a series which will continue over the next several issues.

This *Guide for Hospital Medical Staff Bylaws* is presented in response to the increasing number of requests received by ISMS for assistance in clarifying the relationships that exist among physicians, other health care professionals and hospital corporations.

Confusion about these relationships exists mainly because the relationship of the individual patient to his physician is no longer a simple one. All parties are affected by numerous external trends and forces, including the sub-specialization of medicine; the expensive technical developments that have occurred over the last 40 years; the dominance of 3rd party payers in the funding of care; government regulation of the reimbursement and organization of health care; the increasing significance of anti-trust law in the health care area; the rapid expansion of para-medical and ancillary health care professions; expansion of medical education responsibilities by hospitals; and, perhaps most pertinent, the change in the concept of the American hospital from a charitable organization, exempt from suit, to a business organized to support itself with its own revenues-from hospital patient care *and* other sources.

These bylaws attempt to redefine the essential characteristics of the body of organized physicians within such an institution. It is expected that the approach delineated here will best meet the needs of the patient and his physician in the foreseeable future as the changes referred to above are implemented, proposed, experimented with or imposed by society.

Origin of Project

At the 1981 Annual Meeting, the Illinois State Medical Society's (ISMS) House of Delegates adopted Resolution 37 (A-81), which called upon the Society to develop information and resources to assist physicians in dealing with hospital governing boards and administrators. An ad hoc committee reporting to the ISMS Council on Medical Services was created to implement the resolution.

A review of the available programs and materials on hospital-medical staff relations revealed that the vast majority were produced by hospital oriented agencies, and dealt with hospital/medical staff interactions without first defining and separating the medical staff's responsibility to itself, its members and patient care.

The Committee began by identifying controversial issues involving hospital medical staffs. After considerable discus-

sion and analysis of these issues, it was established that a concise, inclusive well-written medical staff bylaws document was essential before any particular problem could be addressed.

This document was considered to be the nucleus for defining the specific responsibilities of the medical staff to patient care, hospital administration and the Governing Board. Defining the relationship of medical staff members to each other was also considered fundamental to this document. It was noted that, historically, many controversial issues involving physicians with hospitals can frequently be traced to inadequate medical staff bylaws.

Approach and Philosophy

This publication, *Guide to Hospital Medical Staff Bylaws,* represents a year and a half effort by the Ad Hoc Committee on Resolution 37 (A-81). The Committee was composed entirely of practicing physicians of various specialty and philosphical backgrounds. One physician was also an attorney specializing in hospital-physician issues.

The members reviewed all available literature on relevant court decisions, Illinois state law and professional standards related to medical staff bylaws. The Committee intended to create a document that not only provided language illustrating major concepts but also described the reason certain phrases or words were selected. The *Guide* integrates legal interpretations, relevant court decisions, JCAH recommendations, state law requirements and ISMS policy statements as each article of the bylaws is presented.

It is important to note again and emphasize the philosphical approach in this document. The Committee felt it should produce a product clearly defining and separating the rights and responsibilities of physicians from administrative and professional individuals working within a hospital and from those individuals governing or operating the hospital. The following basic principles are reflected in every section: 1) self-government and autonomy of the medical staff; 2) protection of an individual physician's due process rights; and 3) the need for physician direction and supervision of all patient care provided in the hospital.

Many staff bylaws confuse medical staff duties and responsibilities with those of the hospital. The words and phrases chosen in this *Guide* avoid this intermingling of responsibilities, yet recognize the importance of a close, cooperative relationship between the medical staff and the hospital.

The sample language is not intended to be all-inclusive. Parts of this document are intentionally general in nature to permit each medical staff to consider the suggested language and various components in light of its own goals and structure, and the needs and desires of its members. A medical staff should obtain its own separate legal counsel to review its bylaws, rules and regulations. It is suggested that this legal assistance should not be obtained from the law firm representing the hospital. However, the document should be considered as a whole and should not be used in parts without legal counsel assistance, since the *Guide* is intentionally consistent, with one section built upon concepts developed in another.

This document is intended to assist medical staffs in complying with licensure and accreditation requirements, although the Society may not agree with the various requirements and standards set forth by state and voluntary agencies.

Structure of the Guide

The *Guide* is designed to explain to the reader why certain phrases, sections or concepts are important. At the conclusion of this series, an appendix, *Legal Considerations of Medical Staff Bylaws,* will be published to provide further information about legal issues arising from Bylaws.

Each column is divided to allow a close comparison of the specific language and its rationale. Indented material provides the following information: pertinent citations from the legal appendix; requirements for medical staff bylaws as mandated by the Illinois Hospital Licensing Act and its regulations; recommendations from the Medical Staff Chapter of the JCAH *Accreditation Manual for Hospitals;* policy statements of the Illinois State Medical Society and general comments from the Ad Hoc Committee.

The sample language in this document was drafted for a hospital having only physicians as medical staff members, and was approved prior to the development and adoption of the 1984 changes in the JCAH Medical Staff Standards, which permitted hospitals to broaden the composition of their medical staffs. Should a facility's governing body desire to have other types of practitioners affiliated with the hospital, then other language, not inconsistent with state law and accreditation requirements should be made.

DEFINITIONS

Allied Health Professional—A person licensed or certified to provide patient care services under the supervising direction of and who may be employed by a physician member of the Medical Staff.

Emergency—A situation during which serious or permanent harm could befall a patient or where a delay in administering first aid or treatment would place the patient in immediate danger.

Governing Board, Board, Governing Body—The decision and policy-making component of the hospital which has ultimate responsibility and authority over Medical Staff and hospital functions.

He, Him, His—These terms shall be used to refer to male and female persons covered under the Bylaws, Rules and Regulations.

Hospital—The _____ Hospital, _____ Illinois.

Limited License Practitioner—A person licensed to independently practice a defined portion of health care outside the Hospital, who has been granted privileges within the Hospital, consistent with State Law, to practice his profession with his patient, under the general supervision of a physician member of the Medical Staff.

MEC—Medical Executive Committee, the *elected* governing authority of the Medical Staff.

Medical Staff—The formal organized body of physicians serving _____ Hospital, who are privileged to attend patients or provide other diagnostic, therapeutic, teaching or research services in the Hospital.

Medical Staff Year—The period from _____ to _____.

Physician—A person licensed by the state of Illinois to practice medicine in *all its branches.*

Secretary—The *elected* officer of the Medical Staff who is responsible for taking minutes of Staff meetings and sending

out correspondence on behalf of the Medical Staff, or seeing that such correspondence is prepared and sent out by the hospital's or Medical Staff's employee who is hired for the purpose of providing clerical and administrative support for the Medical Staff.

GENERAL COMMENTS

A section on definitions is helpful to clarify terms used throughout the document for those who will be reading and governed by it.

PREAMBLE

WHEREAS, recognizing that the hospitalized patient is best served by having his medical care rendered by a personal physician, and the existence of a self-governing hospital medical staff; and

WHEREAS, only physicians are competent to evaluate the quality of medical care in the hospital, due to their education, training and experience, therefore, be it

RESOLVED, that the physicians of _____ Hospital do hereby organize themselves to assume responsibility for monitoring and controlling the quality of medical care at this institution.

GENERAL COMMENTS

The Preamble or Purposes Sections should define the Medical Staff as a self-governing association devoted to the provision of optimum quality care within the hospital setting. Physician control over medical matters should be emphasized. It should also state that the general purpose of the Staff is to provide an organizational framework through which the Medical Staff recognizes the rights of the individual practitioner in his relationships with the Hospital and the Staff.

The AMA has suggested that the following Preamble be included in all Medical Staff Bylaws:

> The Hospital and the Medical Staff have a duty to cooperate in their mutual responsibility of assuring the highest quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas where medical judgement and the valuation of medical competence are involved, the hospital has a duty to rely upon the judgements and recommendations of the Medical Staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the Medical Staff.

ARTICLE I. NAME

The name of this organization shall be_____Hospital Medical Staff.

ARTICLE II. PURPOSES

The purposes of the_____Hospital Medical Staff include the following:

1. To assure the provision of competent medical care to all patients admitted to the Hospital, or treated in the Hospital's outpatient department, consistent with local medical standards and within the community's resources;
2. To monitor the professional performance of each member of the Medical Staff and the performance and functions of the Allied Health Professionals in the Hospital;
3. To delineate clinical privileges granted physicians and Limited License Practitioners and "specified services" performed by Allied Health Professionals working in the Hospital;
4. To provide educational opportunities to members of the Medical Staff; to encourage advancement in professional knowledge and skill;
5. To initiate and maintain Bylaws, Rules and Regulations for the self-government of the Hospital Medical Staff; and
6. To provide a means to discuss issues with the Governing Board of the Hospital and to ensure that the Governing Board takes no unilateral actions regarding medical matters without consultation with the Medical Staff.

GENERAL COMMENTS

The principle overriding obligation of the Medical Staff is to assure optimal quality of medical care.

JCAH RECOMMENDATIONS

The Medical Staff is to develop and adopt bylaws, rules and regulations to establish a framework of self government and a means of accountability to the Governing Body. These are to reflect current staff practices, be enforced and reviewed annually and revised as necessary.

ILLINOIS REQUIREMENTS

There shall be an active staff . . . which performs all organizational duties pertaining to the Medical Staff. (3-1.2)

The Medical Staff shall be organized in accordance with written bylaws, rules and regulations, approved by the Governing Board. (3-1.1)

The Medical Staff must provide for the maintenance of proper quality of all medical care and treatment in the hospital (3-1.2.a)

Staff duties are to include organizing the staff, adopting rules and regulations for its government, election of its officers (or recommending appointments to be made by the Governing Body regarding all appointments to the staff) and grants of hospital privileges. (3-1.2b) The staff shall also make recommendations to the Governing Body regarding matters within the purview of the Medical Staff. (3-1.2.c.)

ARTICLE III. MEMBERSHIP

Section A. Qualifications and Requirements

Membership on this staff is a privilege extended to a professionally competent practitioner licensed to practice medicine in the State of Illinois, who meets the standards and requirements set forth in these bylaws and whose admission to the staff would be in the best interest of patient care in this hospital.

ILLINOIS REQUIREMENTS

There shall be an active staff which must include physicians, and may also include dentists and podiatrists. (3-1.2)

LEGAL CONSIDERATIONS

Chapter IV. (P. 8-13)

ISMS POLICY

ISMS opposes the development of a JCAH Standard or state law mandating Medical Staff membership to anyone other than physicians licensed to practice medicine in all its branches, and dentists.

JCAH RECOMMENDATIONS

The Medical Staff includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient services independently in the hospital.

GENERAL COMMENTS

Nothing in this section or throughout this document prohibits a hospital from organizing practitioners of other types who are permitted by state law to attend patients in the hospital, if a facility desires such persons.

The phrase "Whose admission to the staff would be in the best interest of patient care in this hospital" allows the Hospital to close its staff as long as it is done impartially and by objective and documented criteria.

Section B. Ethics

Each Staff member shall conduct himself in accordance with the laws of the State of Illinois and the current ethical principles adopted by his profession.

Section C. Conditions and Duration of Appointment

Initial appointment shall be for a one year period. Each reappointment shall be for a period of not more than two years. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as are granted according to these bylaws. Each applicant shall acknowledge his obligation to provide medical care and to abide by the Medical Staff Bylaws, Rules and Regulations.

GENERAL COMMENTS

A short period of appointment permits a reevaluation of a practitioner's credentials at frequent enough intervals to detect and control those persons with diminishing faculties due to age, disease, disability or other interim defect. It can prevent the overlooked retention on the staff of a person who no longer practices at the hospital and should not, therefore, share in the staff's liability. Most importantly, it serves as an opportunity to recognize a staff member's recent training or problems which could result in an increase or limitation of his privileges.

Section D. Procedure for Appointment

Each application for appointment to the Medical Staff shall be in writing, signed by the applicant and be submitted on a form adopted by the Medical Staff and ratified by the Governing Body.

ILLINOIS REQUIREMENTS

The Medical Staff bylaws shall provide for written procedures for accepting and processing applications for membership (3-1.1.a.) and setting eligibility criteria for current and prospective staff members. (3-1.1.b.).

JCAH RECOMMENDATIONS

Medical Staff bylaws shall include the qualifications and procedures for staff membership, including application, appointment and reappointment, periodic appraisal and provisional status.

Qualifications are to be specifically related to proper licensure, training, experience and documented competence. The method for performing the credentials function is also to be included in the bylaws.

1. Required Documentation

The applicant shall have the responsibility of producing adequate information for proper evaluation of his competence, character, ethics and other qualifications, and for resolving any reasonable doubts about such qualifications. The applicant shall be required to furnish copies of the following, as applicable:

GENERAL COMMENTS

The provision of adequate evidence of competence must be the responsibility of the applicant. It is anticipated that the Medical Staff office would aid the applicant with necessary letter writing, secretarial support, timely reminders, etc.

a. Professional school diploma;

b. Documentation of internship, residencies, fellowships and Board Certification;

LEGAL CONSIDERATIONS

Chapter IV, B (P.9)

c. Current Illinois license;

ILLINOIS REQUIREMENTS

The application process must include verification of an applicant's current Illinois license and biennial review of renewed license during the reappointment process. (3-1.1.a.)

d. Current federal and state narcotic license;

e. Current photograph;

f. Letters from at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and character;

g. Letters, if appropriate, from the Directors of the applicant's internship, residency and fellowship programs, supporting his qualifications;

h. Information as to whether the applicant's hospital staff membership status or clinical privileges have ever been

revoked, suspended, reduced or not renewed by any other hospital or institution;

i. Information as to whether his membership in local, state or national professional societies or his license to practice in any state has ever been suspended or terminated or any disciplinary action has been levied;

j. Information regarding any adverse malpractice decision or settlement, any adverse actions by state or federal authorities, or any pending litigation involving the applicant.

GENERAL COMMENTS on h, i and j

The applicant should be asked to supply the Staff with copies of any reports of such actions submitted to the Department of Registration and Education, filed under the mandatory reporting provisions of the Illinois Medical Practice Act.

Hospital Staffs should also request to be placed on the mailing list of disciplinary actions taken by the Illinois Department of Registration and Education. A monthly newsletter lists all final actions taken against MDs, DOs, RNs and other licensed professionals.

ISMS POLICY on j

The Staff should decide if applicants and members will be required to have professional liability insurance as a condition of Staff appointment. ISMS suggests that hospital Medical Staffs take the following steps regarding this issue:

1. If there is a mandate of insurance, Medical Staff Bylaws, rules and regulations should require that Medical Staff members annually provide certificates of insurance to the Hospital.

2. The Medical Staff should be similarly assured of the scope and amount of professional liability coverage carried *by* the Hospital.

3. The Medical Staff should establish limits of coverage deemed appropriate by the Staff based upon risk considerations, such as type of services, type of community, extent of risk identified, historical loss experience and local malpractice climate.

4. Medical Staffs should investigate the difference between "occurrence" and "claims-made" coverage. Information regarding these coverages is available from the Illinois State Medical Inter-Insurance Exchange.

5. If a member of the Medical Staff has "claims-made" coverage, the Staff should require evidence that the "reporting endorsement" or "tail" has been purchased in order to ensure liability coverage should that person retire or leave the staff for any reason.

6. Hospital governing boards and Medical Staffs should have their bylaws, rules and procedures on this subject reviewed by legal counsel.

LEGAL CONSIDERATIONS on j

Chapter IV C. (P.10)

The applicant shall sign and submit with his application a consent form, authorizing the Hospital to obtain information about the competence and character of the applicant for the purpose of evaluating his credentials.

An applicant shall be given a copy of the current Medical Staff Bylaws, Rules and Regulations, and shall state, in writing, that he will abide by them.

GENERAL COMMENT

It is rare that an applicant reads all the verbiage and it is better to obtain an accurate statement rather than a potentially untrue commitment.

An applicant shall indicate on the application form if he has a physical or mental limitation affecting his ability to deliver competent care.

If requested, pursuant to an evaluation of his candidancy, the applicant shall agree to a competent verification of his health status.

ILLINOIS REQUIREMENTS

The bylaws must provide for verifying an applicant's qualifications and privileges, including current health status (3-1.1.g).

2. Approval Process

ILLINOIS REQUIREMENTS

The bylaws must specify a procedure for processing applications for staff privileges that guarantees due process and fair hearing for each such applicant (3-1.1.c).

a. Credentials Committee Review

The Secretary of the Medical Staff shall forward the completed application with accompanying documentation, including the types of privileges requested and references, to the Credentials Committee. The Credentials Committee shall verify the information and investigate the references and privilege qualifications.

The burden of establishing the competence and ethical qualifications of the applicant shall be on the applicant.

GENERAL COMMENTS

Again, state explicitly that the burden of establishing competence is with the applicant—not with the Medical Staff or the Hospital.

Within two months of receipt of the completed application, the Credentials Committee shall forward the applicant's file to the appropriate departments in which the applicant has requested privileges.

GENERAL COMMENTS

This and other time restrictions in these Bylaws prevent the Hospital—or the Medical Staff—from "losing" or

"misplacing" the application. The burden of processing a *completed* application in a *timely* and *fair* manner is delegated to the *Medical Staff.*

Liability ultimately rests with the *Hospital,* not the Medical Staff, for timely processing of the application.

A Department shall, within two months of receipt of the completed application, report its recommendation to the Credentials Committee and return the applicant's package to that Committee.

The Credentials Committee, at its next meeting following receipt of the application and department reports, shall review such reports and forward the application to the Medical Executive Committee (MEC), with a recommendation of acceptance or denial, and, if appropriate, the recommended privileges to be granted.

Within six months of the Hospital receiving the *completed* application, the Medical Staff review and recommendations and the applicant's file are to be forwarded to the Governing Board for action.

b. MEC Review

The MEC, at its next meeting, but no later than two months following receipt of the Credentials Committee report, shall review such reports and, if favorable, forward the application to the Governing Board, with a recommendation of acceptance and the recommended privileges to be granted.

If the MEC's recommendation is to deny the application, this recommendation shall be forwarded, in writing, to the Governing Board with the reasons for the denial. Should additional time be required for processing for any reason, the applicant will be so informed. However, in no case shall the MEC fail to forward the application with its recommendation within two months of receiving it from the Credentials Committee.

The applicant will be notified by the elected Medical Staff Secretary of any adverse recommendation and offered an opportunity to respond.

c. Governing Board Review

The Governing Board should act on the application at its next meeting following receipt of the file, MEC recommendations and any response by the applicant. If the Board does not adopt the Medical Executive Committee recommendation, it should refer the matter back to the MEC for further consideration, stating the reasons for such action and setting a time limit, not to exceed two months, within which a report shall be made by the MEC and forwarded back to the Board.

The applicant will be notified by the Medical Executive Committee that the application is under review by the MEC, and told a recommendation will be submitted to the Board within the next two months.

After receipt of the reconsidered opinion, the Board should make a final decision on the application within two months of having again received the file.

When the Board has taken final action on an application for membership to the Medical Staff, the Board, acting through the Administrator, should notify, in writing, the Medical Staff Secretary who, in turn, shall notify the applicant by certified mail of the action taken, within 14 calendar days after the decision has been made.

All approved applicants shall be placed on Provisional Medical Staff status for at least twelve months, after which time the applicant's status as a member of the Medical Staff will be advanced or terminated.

GENERAL COMMENTS

Following a provisional period, a practitioner will have demonstrated the extent of his ability to provide competent care and to comply with the staff Bylaws and Rules. The Medical Staff, having such information, should either advance the person to the next staff status or terminate his staff appointment for cause.

It is inappropriate and unfair to keep a person in the provisional category once evidence and experience on his performance is available and clear.

d. Denial of Application

If the Governing Board rejects appointment of the applicant, the elected Medical Staff Secretary will notify the applicant by certified mail within 14 calendar days after the decision to reject has been made. Such notice shall include the reasons for rejection and a description of his right to appeal the decision as delineated under Article IV., Sec. F. of these Bylaws.

LEGAL CONSIDERATIONS

Chapter II (P. 2-5)

ILLINOIS REQUIREMENTS

The bylaws must provide for a policy that specifies a procedure for processing applications for staff privileges and guarantees due process and fair hearing for each such applicant. (3-1.1.(c))

GENERAL COMMENTS

Since Illinois law appears to require due process for rejected initial applicants, some form of appeal should probably be incorporated in the staff's bylaws. However, the appeal process need not be as extensive for initial applicants as for current staff members.

The applicant shall have ten days following receipt of such notice to request a hearing. A request must be in writing and sent by certified mail to the Medical Staff Secretary. Failure to request a hearing shall be considered an acceptance of the decision and a waiver of all rights to a hearing.

JCAH RECOMMENDATIONS

The bylaws are to provide a mechanism to provide a fair hearing and appellate review when requested by a practitioner in connection with Medical Staff recommendations for denial of staff appointment, denial of reappointment or curtailment, suspension or revocation of privileges. It is recognized that the mechanism for individuals applying for initial appointment or

privileges may differ from that applicable to Medical Staff members.

An applicant denied membership may re-apply for staff membership one year following the date of his initial completed application.

Section E. Privileges

1. Initial Privileges

The applicant must apply for privileges on the form provided by the Medical Staff Secretary, which accompanied his application for membership.

Initial privileges shall be provisionally granted following: (1) documented verification of the applicant's education, training, competence and other relevant information; (2) recommendation by the appropriate Department(s); (3) approval by the Medical Executive Committee; and (4) approval by the Governing Board.

JCAH RECOMMENDATIONS

The bylaws are to provide for a mechanism for delineation and retention of privileges, and reduction or withdrawal of privileges.

GENERAL COMMENTS

Privileges are granted *provisionally* because they are based on information from other institutions. Privileges are granted *un*-provisionally only to practitioners who have been observed in their practice by Staff members during the provisional period and have advanced to permanent Staff status.

a. Proctor

The Medical Executive Committee shall assign at least one Active Staff member to serve as a proctor for the applicant during the Provisional status period.

The applicant shall acknowledge in writing the right of a proctor or a department chief to take over a case whenever the assigned proctor feels it is necessary to do so to safeguard the patient's health or well-being.

The applicant shall have no cause to complain nor any Cause of Action in law or equity against a proctor who acts in good faith and without malice, or against the hospital, its Medical Staff, or any component thereof, acting in good faith and without malice. A statement of this waiver shall be explicitly made in writing by the approved applicant, with his signature notarized.

GENERAL COMMENTS

The Chairman of a clinical Department has the right and duty to preempt the care of the patients of an incapacitated physician not otherwise covered. This clause is designed to state this policy explicitly and to protect the Staff members and the hospital.

"Acting in good faith and without malice" guards the applicant from actions of staff members acting for reasons other than patient welfare. This clause puts Medical Staff members on notice that any such preemption is subject to later justification.

2. Increase in Privileges

Requests for increased privileges during the re-appointment process will be processed in the same manner as an initial application for privileges.

3. Temporary Privileges

Temporary privileges may be granted by the Administrator, acting on behalf of the Governing Board, but only upon recommendation by the Chief of Staff and the appropriate Department Chairman, for a period not to exceed three months.

GENERAL COMMENTS

Temporary privileges may be granted for cause in extraordinary situations, but not arbitrarily or capriciously by the Governing Board or Administration. Such privileges should be with the concurrence of the Medical Staff officers.

Temporary privileges are written to provide flexibility in the Medical Staff and Hospital.

Such privileges may be given to a person licensed by the state of Illinois pending action on his application for staff membership; following receipt of the completed application and upon receipt of documented evidence of his competence and ethical standing.

The practitioner with temporary privileges shall act under the supervision of the appropriate Department Chairman or that Chairman's designee.

The granting of temporary privileges shall not be a substitute for regular processing of the Staff application. Temporary privileges will cease upon the withdrawal of the recommendation(s) previously provided by either the Chief Staff or a Department Chairman, or by withdrawal of the appointment by the Administrator.

Suspension of temporary privileges shall not entitle a person to a hearing or to the appeal process, or alter the orderly completion of the credentialing process.

Under extraordinary circumstances, as in the appointment of a new Chairman of a Department (*e.g.,* Pathology), the Board may grant immediate Active Staff membership with all perquisites pertaining to that status, including membership on the Executive Committee of the Medical Staff and full voting privileges, PROVIDED, there is a contractual agreement with such a person that such appointment shall be NULL and VOID on the occurrence of any one of the following:

GENERAL COMMENTS

This section is inserted to prevent the Hospital and/or the Medical Staff from being embarrassed by the lack of necessary support services occasioned by the death of the incumbent or some other catastrophe.

a) Failure of his application for Staff membership to meet

the standards of credentialling applied to all members of the Medical Staff in the usual manner and over the usual time period for evaluation of credentials and application;

b) Failure of such candidate to fulfill his contractual obligation to the Hospital, as determined by competent referees, during the time his application for staff membership was being regularly processed by the staff; or

GENERAL COMMENTS

The staff and Hospital should develop a procedure, in anticipation of such a situation, to identify how totally impartial referees will be selected.

c) Failure of the candidate to meet the specific credential requirements for the post held, as distinct from the credential requirements for membership on the Medical Staff in general.

AND FURTHER, Providing that such immediate original appointment to the Active Category of the Medical Staff shall be made ONLY with the written concurrence of the Chief of Staff of the Medical Staff and a concurring majority of the Medical Executive Committee.

4. Emergency Privileges

In case of an emergency, any Staff physician may be permitted and assisted to do everything possible to save a patient's life or save a patient from serious harm. This action by the physician shall be to the degree his license permits and regardless of his department, Staff status or clinical privileges.

Persons who identify themselves as physicians during a disaster should present, to those in charge, identification proving licensure status. This status should be verified by contacting the Illinois Department of Registration and Education, *if possible, before* such physician functions in patient care.

A Staff member providing services under this section, which are beyond his privileges, shall provide to the MEC a description of the emergency situation and his actions during that period of time.

GENERAL COMMENTS

This provision recognizes accepted practice—and eliminates the possibility of a hospital employee inhibiting the provision of necessary patient care in an emergency situation.

5. Admission Privileges of Limited License Practitioners

Each patient of a limited license practitioner shall be admitted to the hospital by the co-admission of such patient by a physician member of the Medical Staff and the attending limited license practitioner. The physician will be responsible for the overall medical care of the patient.

ILLINOIS REQUIREMENTS

All persons admitted to the hospital shall be under the professional care of a member of the Medical Staff. Patients admitted by a podiatrist or dentist shall be under the care of both the admitting staff member and a physician member of the Staff. The doctor of podiatric medicine or the doctor of dental surgery shall be responsible for all care within the limits of the privileges granted to him; the physician is responsible for all aspects of general medical care. (3.2)

Section F. Leave of Absence

1. Request for Leave

A member of the Medical Staff may request a leave of absence by submitting a written statement to the MEC, stating the period of leave and the reasons for the request. The time period specified shall not exceed the person's Staff appointment period most recently granted.

The MEC may place certain conditions on the request for a leave of absence, as deemed appropriate. During the leave, the person's staff privileges and responsibilities are considered in abeyance.

GENERAL COMMENTS

This provision permits the Medical Staff to conduct a mini-review of a member's status on his return. It can be used to deal with impaired practitioners seeking treatment or in other situations where a 1-2 year period of time is requested.

2. Reinstatement

A Staff member currently on an approved leave of absence may request reinstatement of his Staff status and privileges by submitting a written notice of his intent with the MEC. The request shall be submitted within 30 days prior to the desired date of return.

A report of the person's activities relevant to the reinstatement of his status and privileges shall be included with his request.

The MEC shall make a recommendation to the Governing Board on the request for reinstatement within 10 days of its receipt.

Section G. Reappointment

1. Renewal Process

At least one hundred fifty days prior to the termination of a staff member's membership period and privileges, the Medical Staff Secretary shall notify the member and his department(s) that his membership and privileges are up for renewal consideration.

The Departments will have 30 days to undertake and complete a review of a Staff member's performance, giving consideration to professional competence, clinical judgment and ethical conduct.

Sociability and personality may not be among the criteria for retention.

LEGAL CONSIDERATIONS

Chapter IV. D. (P.8-13)

ISMS POLICY

The results of recertification examinations should not be the sole criteria used by hospitals in the granting of clinical privileges.

GENERAL COMMENTS

This clause defines the only criteria by which a staff member will be judged for reappointment. Specifically excluded is such criteria as "ability to work well with others" which has been used to unfairly deny privileges to those who criticize hospital workers, nursing staff—or indeed, their colleagues.

Should a person be denied privileges by the Governing Board due to the utilization of non-clinical criteria, then any responsibility for such denial will clearly rest with the Board.

At least one hundred twenty days prior to termination of the membership period, the Medical Executive Committee should evaluate the candidate for renewal of membership and privileges for an additional two year period and transmit its recommendation to the Governing Board.

Before reappointment, the member may be requested to reaffirm his mental and/or physical capability to render competent care. The elected Medical Staff Secretary will verify the current status of the member's state licenses and any actions taken against that member in the previous two years.

2. Denial of Reappointment

When the Medical Executive Committee recommendation to the Governing Board is to deny reappointment, to reduce privileges, to deny a requested increase in privileges, or to deny an increase in membership status, the reasons shall be stated and the member notified by certified mail, return receipt requested, of such decision and the reasons therefore.

GENERAL COMMENTS

Receipt of a notice of an adverse decision is mandated to avoid defects in the delivery system (U.S. Post Office or other) denying a staff member important rights.

Such notice shall advise the member of his right to a hearing before the MEC, as described in Article IV. F. of these Bylaws, and the need for him to request a hearing, by certified mail, within ten days of receiving such notification. Prompt personal notice by the Medical Staff Secretary shall also be attempted.

Failure to request a hearing within this time period, absent good cause, shall be considered acceptance of the MEC recommendation to the Governing Board and a waiver of all rights to a hearing.

Editor's Note:

The ISMS Guide to Medical Staff Bylaws will continue next month, beginning with Article IV: Discipline. The series will be carried over several issues and, on conclusion, copies of the complete document will be available upon request from the ISMS headquarters offices.

Obituaries

***Bertucci, Joseph A.,** Rolling Meadows, died February 18, 1984 at the age of 68. Dr. Bertucci was a 1941 graduate of Loyola University Stritch School of Medicine, Maywood.

***Cant, John F.,** Park Ridge, died February 22, 1984 at the age of 76. Dr. Cant was a 1935 graduate of Rush Medical College.

***DeTrana, Frank A.,** River Forest, died February 20, 1984 at the age of 69. Dr. DeTrana was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

***Galapeaux, Edward A.,** Tucson, Arizona, died February 29, 1984 at the age of 70. Dr. Galapeaux was a 1941 graduate of Loyola University Stritch School of Medicine, Maywood.

****Mickus, Matas,** Medinah, died February 12, 1984 at the age of 95. Dr. Mickus was a 1916 graduate of the First Moscow Order-of-Lenin Medical Institute, Moscow.

***Miller, Walter U.,** Crete, died January 13, 1984 at the age of 84. Dr. Miller was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

****Roper, Kenneth L.,** Chicago, died January 31, 1984 at the age of 85. Dr. Roper was a 1922 graduate of Creighton University School of Medicine, Omaha.

***Stewart, Wendell,** Macomb, died January 28, 1984 at the age of 49. Dr. Stewart was a 1959 graduate of Baylor College of Medicine, Houston.

***Wood, Edwin,** Mt. Vernon, died January 25, 1984 at the age of 71. Dr. Wood was a 1945 graduate of the University of Utah College of Medicine, Salt Lake City.

***Zivin, Israel,** Wilmette, died February 23, 1984 at the age of 66. Dr. Zivin was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS Member*
***Indicates Member of Fifty Year Club*

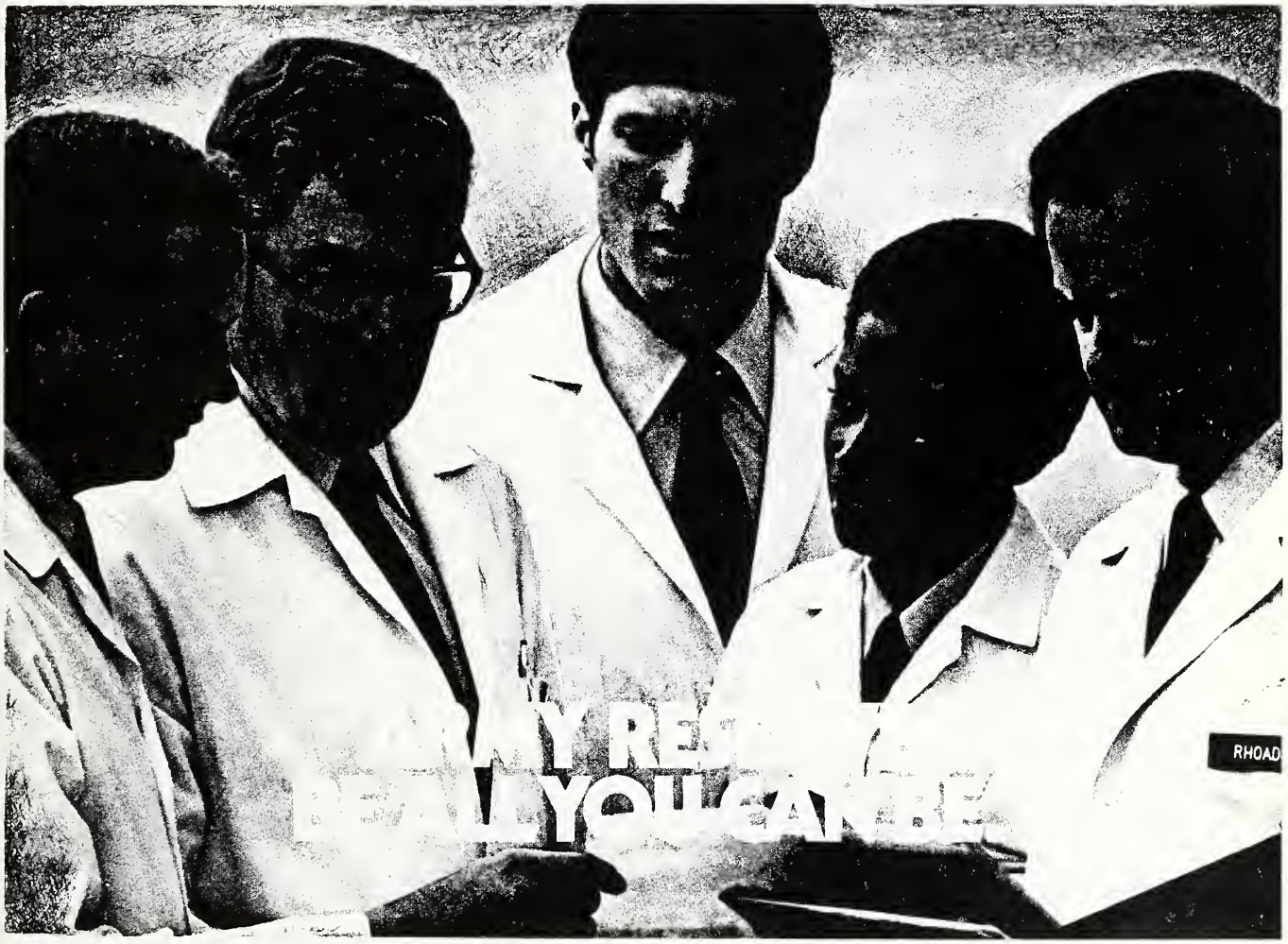
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Additional NMR information on page 285

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 165, No. 4
April 1984

Part Two: Cosmetic Surgery for Breasts, Trunk and Extremities

Plastic Surgery Update

By Robert M. Swartz, M.D. And Robert E. Knode, M.D./Chicago

This is a continuation of an article begun in the last issue of the Journal. *It is intended to provide physicians with a more thorough understanding of cosmetic and reconstructive surgery of breasts, trunk and extremities. Progress in techniques for these areas of the body makes such surgery practical and successful for many patients. Understanding the indications for such surgery, the techniques used and the benefits obtained by patients can be a valuable asset to physicians in clinical practice.*

The development of new materials and the evolution of surgical techniques have led to more advanced methods for surgical reconstruction of breasts, areas of the trunk and extremities. Plastic surgery of the female breast now enables enlargement, reshaping, reduction and reconstruction. Plastic surgery of the trunk and extremities now includes approaches for altering the contour of the abdomen, arms, hips, buttocks and thighs.

Augmentation Mammoplasty

Enlargement of the female breast is the most common cosmetic surgical procedure performed in the U.S.A. About 72,000 operations are done each year. The procedure consists of the placement of a breast implant, usually of silicone gel, in either the retromammary or retropectoral plane, depending upon the clinical situation.

It is essential that the surgeon develop a large capacity pocket in the proper plane to hold the appropriate sized implant. Only by constructing a large space, obtaining meticulous hemostasis, and following a careful post-operative program can natural appearing and feeling results be obtained. During recent years the instillation of a dilute solution of kenalog and bacitracin has improved the percentage of soft and natural feeling post-augmentation results. Where an extremely thin subcutaneous layer exists, often a retropectoral position is chosen for proper contouring of the area.

A variety of incisions can be used but the inframammary remains the incision of choice because it permits a very extensive pocket dissection and meticulous hemostasis. The resultant scar is less than two inches long and can be nearly invisible if properly placed and carefully closed. Patients rarely object to the scar itself in view of the improvement in breast contour which can be obtained.

The greatest drawback to breast augmentation involves the occurrence of a capsular scar contracture about the implant. When this occurs, the breasts are the site of relatively unnatural firmness. Many patients do not object to a mild or moderate firmness, but marked contracture and hardness of the breasts is undesirable. Various techniques to remedy this situation are available. These include a squeeze technique in which the scar is manually torn without resorting to any additional surgery.[1] Occasionally, reoperation is the treatment of choice.

Augmentation mammoplasty is generally carried out as outpatient surgery under local anesthesia. A sedative is given so that the administration of the anesthetic block is not unduly painful.

There has been no evidence to date indicating a greater occurrence of carcinoma of the breast following breast augmentation. Also, the detection of neoplasia is not any more difficult. These facts must be emphasized to patients who consider and elect such surgery, along with the importance of self-examination and physician examination, as for all women.

See Figures 1 and 2 for techniques and examples of augmentation mammoplasty.

Reduction mammoplasty

Pain in the back, neck, shoulder

Figure 1.
Retromammary augmentation mammoplasty

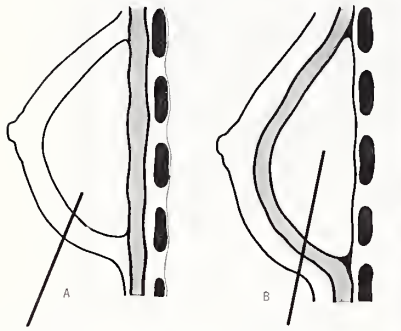


Figure 2A (Before)

Figure 2B (After)

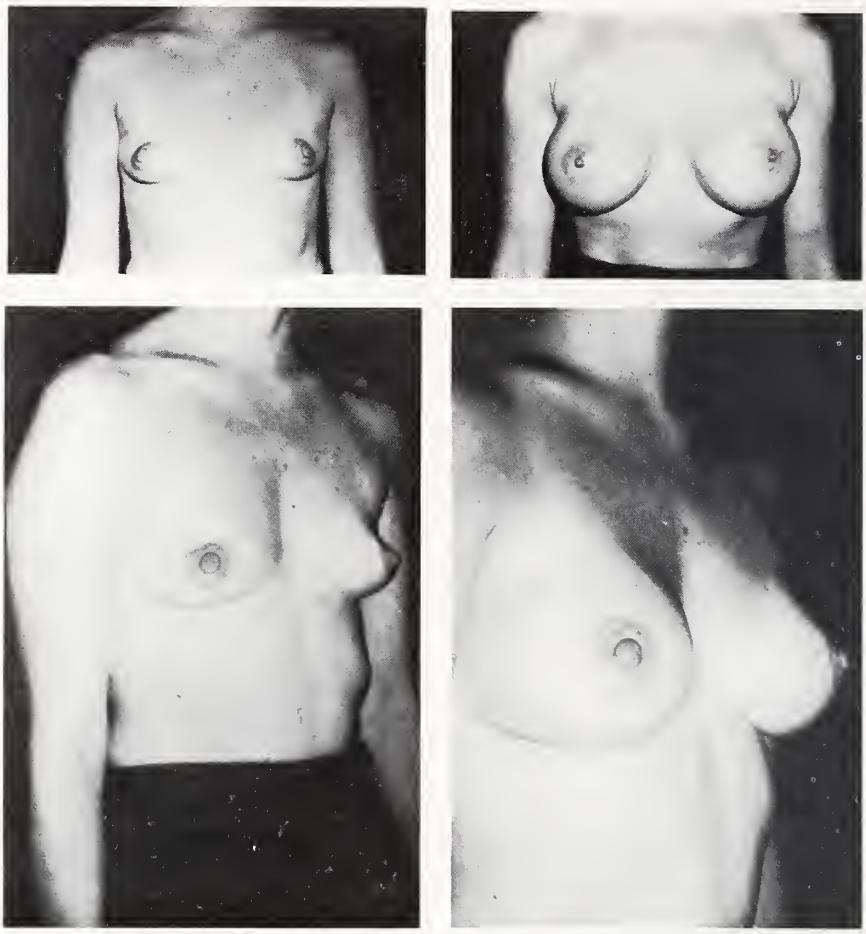


Figure 2
Retromammary augmentation mammoplasty

groove and breast areas themselves can often be alleviated with surgery to reduce breast size. About 32,000 of these procedures are done each year in the U.S. Reduction mammoplasty is usually performed on an inpatient basis under general anesthesia. The procedure consists of the superior transposition of the nipple-areolar complex on a vertical or inferior pedicle containing an intact vascular and nerve supply.[2] Breast tissue is removed from beside and behind the pedicle. The proper preoperative markings for nipple position and skin and breast excision are of extreme importance. Meticulous attention to hemostasis can prevent most complications; indeed, the complication rate is low.

With attention to detail, very aesthetic breast form can be obtained. Thus, the improvement in the breast area can be both functional and cosmetic. Scarring on the breast surface usually takes the form of periareolar, vertical and inframammary transverse components. Figures 3 and 4 show the pattern of such scarring. The nature of scarring in this operation will vary, depending on the patient's tendency to scar formation. It is usually not objectionable and rarely is the cause of great concern post-operatively. Sutures are removed after 7-10 days, at a time when most patients have already returned to employment or household chores. Unlimited activity is allowed approximately one month after surgery.

Mastopexy

Reshaping of the breasts can be performed on an out-patient, local anesthetic basis. Mastopexy follows similar patterns to those used in reduction mammoplasty but is less extensive in scope, as breast tissue is not resected. The extent of scarring is similar to that in breast reduction and can be minimized with careful plastic closure. Often mastopexy and augmentation are performed during a single operative session if lifting, reshaping and enlargement of the breast profile are desired.

Post-Mastectomy Reconstruction

Reconstruction of the female breast following mastectomy is among the most gratifying operations in the armamentarium of plastic surgeons. Over the last several years, techniques available in this effort have advanced to the point where it is a rare situation indeed that does not allow for satisfactory breast reconstruction.[3]

The simplest form of reconstruction consists of the placement of a breast implant formed of silicone gel (or partially filled with saline solution) beneath the remaining skin and pectoralis-serratus muscle layer, if this remains. A very extensive pocket dissection is necessary to obtain an appropriate space to hold the implant. Commonly, procedures to reduce, enlarge and/or reshape the opposite breast are performed in conjunction with post-mastectomy reconstruction.

Prophylactic contralateral mastectomy with immediate reconstruction may also be performed. This is indicated in cases of extensive atypical cellular hyperplasia, extensive microcalcification or familial carcinoma.[4] When performed in conjunction with a breast reconstruction, it seems that total mastectomy is the prophylactic procedure of choice. It allows for the reconstruction of bilaterally similar nipple-areolar complexes, which have a cosmetic advantage over the so-called subcutaneous mastectomy.

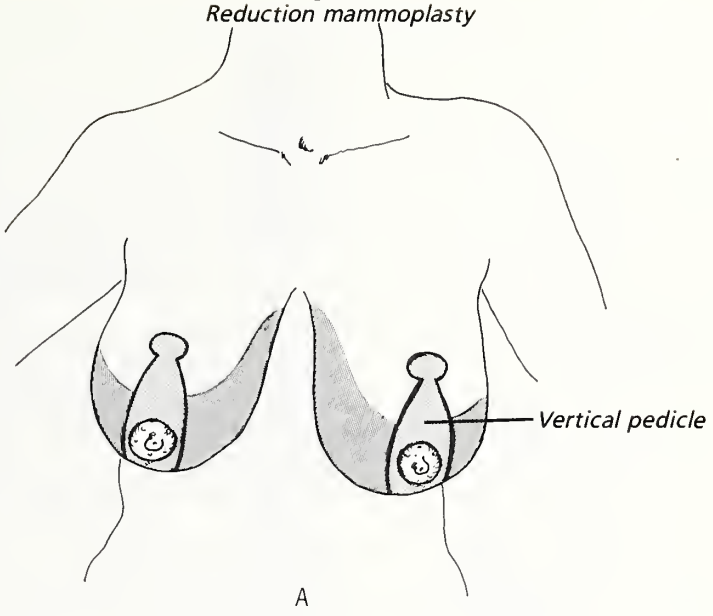
Our approach is to perform single stage reconstructions whenever possible. However, the most difficult aspect of combining procedures is the proper placement of the reconstructed nipple-areolar complex. In many cases, if a proper placement of this cannot be projected, delay of this part of the reconstruction is advisable.

The nipple-areolar complex can be reconstructed from a variety of materials, including those present at the mastectomy site, on the opposite breast, or from the perineal region. The color and texture of the contralateral areola determines the choice of the skin graft site for the areolar reconstruction. Halving techniques on the opposite nipple are appropriate, but ear lobe or labia minora also can serve as the donor site for the reconstructed nipple. (See Figures 5, 6, and 7.)

Myocutaneous flaps, usually of the latissimus dorsi muscle, are necessary for the reconstruction of more radical defects or where skin deficiency exists.[5] The resultant donor site scar is a small price to pay for good reconstructed breast contour and the functional deficit from sacrifice of the latissimus dorsi muscle is surprisingly small. Most commonly, implant insertion is combined with rotation of the latissimus dorsi flap thus yielding one stage breast mound reconstruction. Placement of the nipple-areolar complex in cases such as this must await a second stage, performed several months later, after the final breast form has been obtained. (See Figures 8, 9 and 10.)

Even in the simplest form of reconstruction, the substitution of an internal prosthesis for a previously clumsy, sometimes embarrass-

Figure 3
Reduction mammoplasty



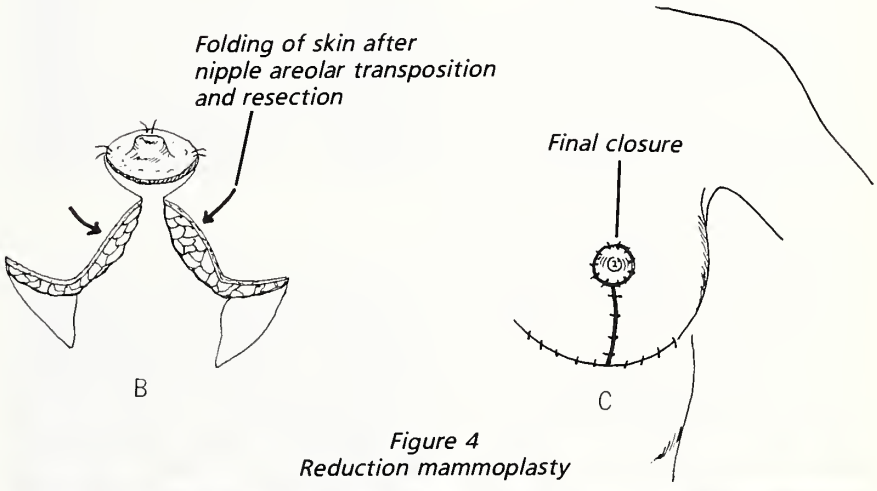


Figure 4
Reduction mammoplasty

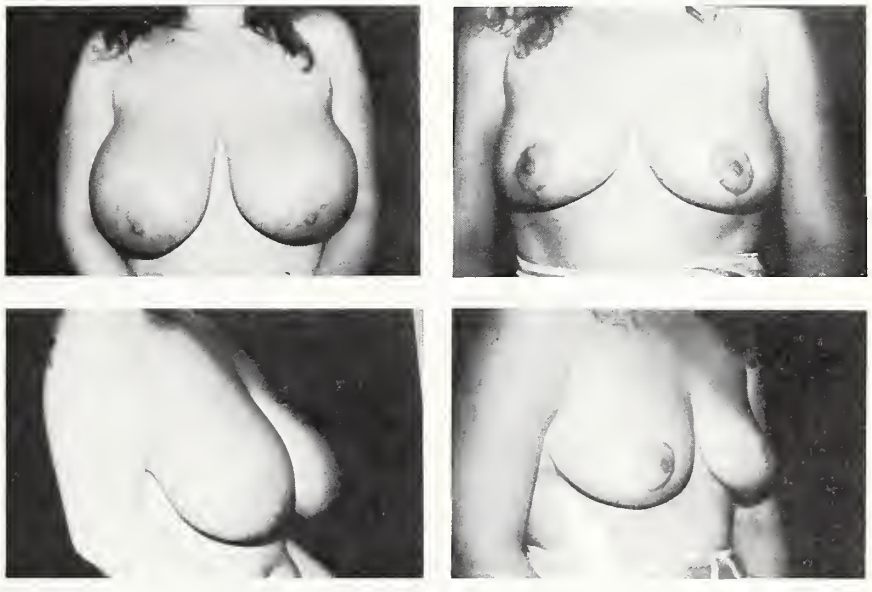
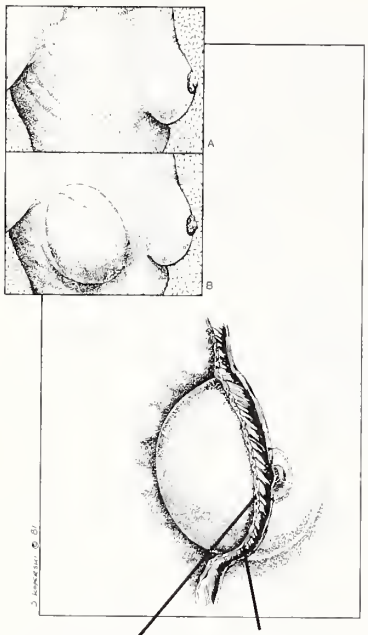


Figure 4A (Before)

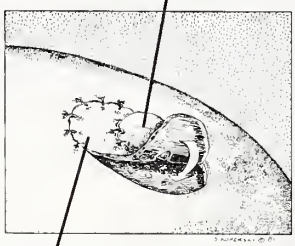
Figure 4B (After)

Figure 5
Placement of breast implant



Implant placement beneath pectoralis and serratus muscle layer if possible

Figure 6
Nipple reconstructed from portion of contralateral nipple, ear lobe or labia minora



Areola reconstructed with skin graft from contralateral breast, upper thigh or postauricular area

Figure 7
(At right) Single stage reconstruction right breast; nipple-areola and mastopexy, left breast

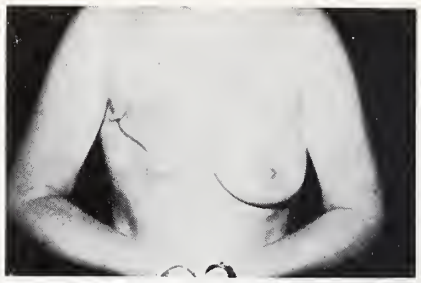


Figure 7A (Before)



Figure 7B (After)

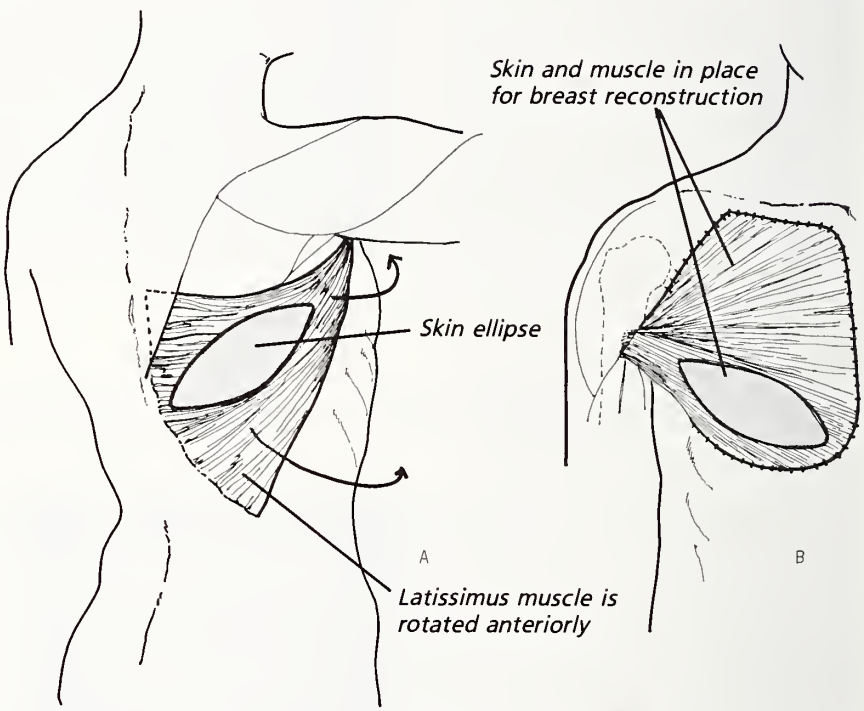


FIGURE 8
Use of myocutaneous flap

ing and uncomfortable external prosthesis, is a giant step forward. Satisfaction is greatly increased in cases where an aesthetic substitute can be obtained. Patients who have undergone post-mastectomy reconstruction are among the most gratifying in a plastic surgeon's practice.

There is no data to support concern about causation of recurrence of breast carcinoma by these procedures if they are properly performed and timed. Additionally, there should be no concern with the masking of the detection of a recurrence, if unfortunately it does occur. Plastic surgeons attempt to place breast implants, where possible, beneath the pectoralis-serratus muscle layer so that the subcutaneous plane remains undisturbed for follow-up examination. Of course, in cases where the primary tumor is large, bulky or skin-invasive, reconstruction must be deferred for several years to allow for the detection of a likely local recurrence. However, where this is not the case, early reconstruction, within several months of mastectomy, can be performed once the operative site has softened and become supple and ready for a second procedure. In some cases immediate reconstruction can be performed, particularly where proper teamwork can be established between the general surgeon, oncologist, and reconstructive surgeon.

The relatively new procedure using a rectus abdominus flap[6] has not yet stood the test of time but seems as though it will have a place in breast reconstruction in a patient with a lax abdominal panniculus and where simpler forms of reconstruction are not possible. The sec-

Figure 9A (Before)

Figure 9B (After)



Figure 9
Latissimus dorsi reconstruction, left breast

Figure 10A (Before)





Figure 10B (After)

Figure 10
Latissimus dorsi reconstruction with nipple areolar reconstruction

ondary benefit of abdominoplasty is attractive and the donor scar placement is excellent. Only time will determine if this form of reconstruction indeed becomes a standard approach. (See Figure 11.)

Prophylactic Mastectomy

Prophylactic removal of the female breast has been discussed in an earlier section. There is a good deal of debate over the extent of prophylaxis obtained with mastectomy, but statistics seem to bear out its value.[7]

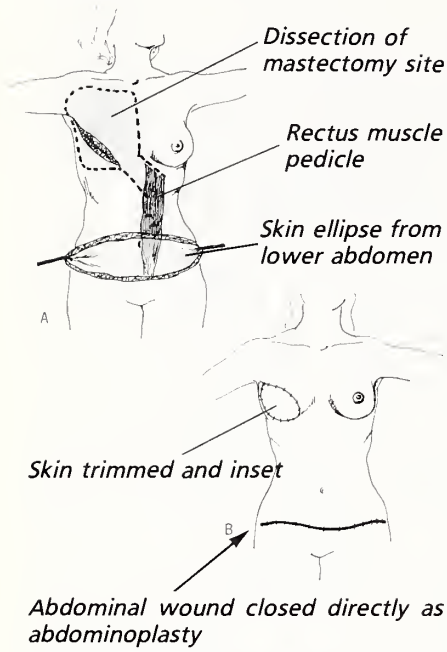
The subcutaneous mastectomy in most cases consists of the near-total removal of breast tissue through an inframammary incision with immediate or delayed reconstruction of the breast, placing the necessary implants in the subpectoral-subserratus plane. This procedure is acceptable for patients with extensive precancerous dysplasia, family history, or even severe cancer phobia. The cosmetic limitations of the operation should be emphasized preoperatively, especially to those patients who believe that it is similar or analogous to augmentation mammoplasty. While the cosmetic results can be acceptable, they are not of as good a quality as those of augmentation mammoplasty. The medical nature of this operation must be emphasized and strict indications followed.[8] When this procedure is performed bilaterally, there is a cosmetic advantage in the preservation of the normal nipple-areolar complex. Patients should be aware that numbness of this region is the rule following properly extensive prophylactic mastectomy.

Body Contouring Procedures

Plastic surgery of the trunk and extremities can take many forms including procedures for altering the contour of the abdominal, arm and hip areas. Newer operations have recently been described which use suction-assisted lipectomy for contouring of these areas as well as calf, knee and ankle regions. While not yet proven in their efficacy, these techniques show promise in attaining improved contour with minimal scarring. The magnitude of many of these operations requires inpatient hospital stays and a general anesthetic. It is with these operations that the patient must consider the "trade" made in assuming a scar in the surgical region in exchange for an undesired body contour. Frequently the patient regards this as a satisfactory trade and the surgery is performed with this understanding.

Some more common body con-

Figure 11
Use of rectus abdominus flap



touring procedures are discussed below.

Abdominal Dermo-Lipectomy

This procedure is carried out through a long incision extending across the suprapubic region from well lateral to the iliac crests. The placement of this incision is vital, as the plastic surgeon attempts to have the resultant scar in the bikini area.[9] Through this incision undermining of the panniculus is carried out to the xiphoid area in the midline and the costal margins laterally. After the assurance of precise hemostasis, it is often desirable to perform a repair of a rectus muscle diastasis, using non-absorbable suture. The skin is then pulled inferiorly and the operating table flexed; excess skin is excised and wound repair carried out. An incision is made during the course of closure at a suitable level in the midline so that the umbilical stalk can be pulled to the skin surface and repaired. Suction drainage is usually instituted and an abdominal binder is used for the next several days. After a day of bed rest in a semi-flexed position, the patient may begin a gradual resumption of ambulation and is most often discharged on the third post-operative day.

Refinements in this procedure include various areas of lipectomy, particularly over the iliac crest and periumbilical regions to obtain an aesthetic abdominal contour. While the quality of scarring in the abdominal wound may vary, it is usually quite satisfactory if well placed. It seems wise that abdominal lipectomy should not be elected by female patients prior to the termination of their child bearing years, as performance before this time would yield a result which is later compromised. The other common indication for abdominal dermo-lipectomy is, of course, extensive weight loss. In such cases it is often performed in men as well as women. (See Figures 12 and 13.)

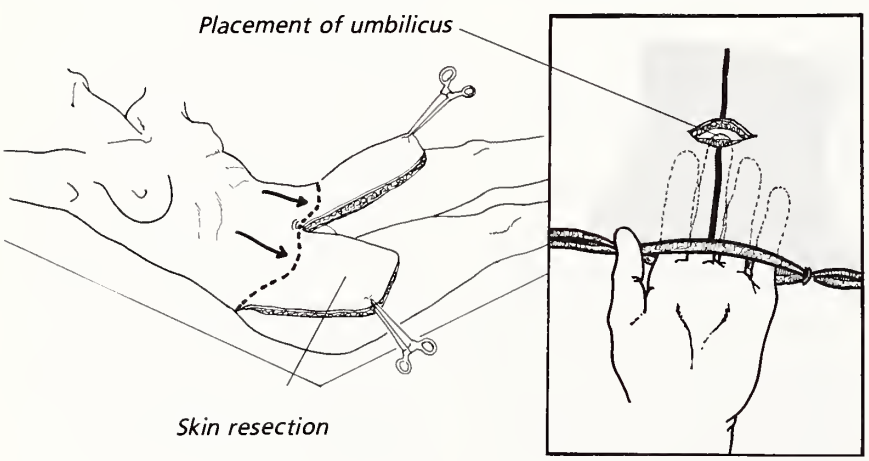


Figure 12
Abdominal lipectomy

Figure 13
Abdominal dermolipectomy with rectus diastasis repair



Figure 13A (Before)



Figure 13B (After)

Thigh lipectomy

Thigh lipectomy can be appropriately performed in the lateral thigh and buttock region and in the medial thigh. It is done for the correction of various forms of lipodystrophy with a maldistribution of fat in the "riding britches" deformity. The sagging skin of the medial thigh can be corrected by excision of a modified ellipse of skin in a patient who has usually undergone an extensive weight loss with secondary sagging.

Procedures for lipectomy lower in the thigh region are generally unsatisfactory because of the scar which results from longitudinal skin excision. The medial and lateral scars which result from upper thigh lipectomy can be well placed, once again, in the bikini area.

The technical aspects of this surgery involve various maneuvers to suspend the lower wound edge beneath the upper to maintain a more prolonged correction of contour.

These operations require hospitalization and general anesthesia,

with the patient usually discharged from the hospital three days post-operatively. Sutures are removed approximately ten days after surgery and activities may slowly be resumed during the next two to four weeks.

Arm Lipectomy

This operation involves removal of excess skin and fatty tissue from the upper arm. It usually involves removal of a modified ellipse of tissue from the medial arm so that placement of scarring can be in a relatively hidden position. However, here the resultant scarring is often a deterrent. The procedure is, however, very satisfactory for patients who have undergone massive weight loss, as the laxity in such cases can be extreme and of great annoyance. In many cases, arm lipectomy can be carried out on an outpatient basis. Occasionally it is done in two separate stages to diminish the functional disability of the bilateral procedure. However, bilateral performance is more often the rule.

Suction Assisted Lipectomy

Various procedures for the removal of unwanted fatty tissue through small incisions recently have been applied to several anatomical areas including the arm, lower abdomen, thigh, buttocks, and lower leg. A mechanical device using a suction currette connected to a one atmosphere suction apparatus is used, with resultant liquification and removal of the fatty tissue. In many cases a waviness of the operative area results, but this seems to be a satisfactory trade for many patients to make. Younger patients with good tissue turgidity and skin elasticity are the best candidates for such a surgical approach.

A more popular method involves honeycombing of the area through multiple suction tunnels rather than the opening of a large area of subcutaneous undermining. By using the former approach, fewer complications result and, because of the blunt nature of the dissection, the blood vessels to the overlying skin remain undisturbed. Most plastic surgeons are in the very early stages of evaluating the mechanical suction device as an approach to lipodystrophy and other dysharmonious areas of obesity.

Most patients undergoing lipectomy in this way can return to normal activities in about two weeks and to the most strenuous activities in about six weeks.

Summary

Possibilities now exist to improve personal appearance through plastic surgical procedures performed on the face and various parts of the body. Because of improved techniques, plastic surgeons are now able to assist many patients in overcoming characteristics which some regard as hindrances to acceptance and success. However, plastic surgeons urge physicians and other professionals that the psychological motivations of their patients be closely examined. While plastic surgery may offer hope for a better quality of life for some patients, it is not the panacea for all who have psychological problems. ◀

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The Short Versus the Long Course

Preoperative Radiation Therapy in Cancer of the Urinary Bladder

By Wagih M. Shehata, M.D., Foroogh K. Jazy, M.D. and David C. Henning, M.D./Cincinnati

This paper recounts the experience of 52 patients receiving preoperative irradiation between January, 1969 and October, 1980. Eighteen patients received 4,500 rad over a period of 4½ weeks (Group I) and 34 patients received 2,000 rad in one week (Group II). All patients were classified into Stages B1, B2, C, D1 and D2 carcinoma of the bladder and included 10, 20, 16, 4 and 2 patients, respectively. Seventeen percent and 9% of the surgical specimen in Group I and II, respectively, contained no residual disease. Enhanced tumor reduction, diminished pelvic node metastases and a greater chance for segmental resection was seen in Group I when compared to Group II patients.

The overall one, three and five year disease-free survival rates were 85%, 55% and 46%, respectively. There was no difference in survival between the two groups. The five year disease-free survival was 63% in patients with tumor reductions as compared to 20% in patients without tumor reductions. The significance of the short versus the long course is discussed.

Several reports have shown the superiority of combined preoperative irradiation and cystectomy over either radiotherapy or cystectomy alone.[1-7] Improved results are probably due to addition of preoperative irradiation rather than improvements in surgical techniques.[1,2,6] The optimal time/dose relationship of preoperative irradiation is not exactly known. Batata, *et al.*,[8] and Whitmore, *et al.*,[6] implied in a retrospective study that the survival is similar in patients treated by a short or a long course of preoperative irradiation followed by radical cystectomy.

The absence of definite criteria as a guideline for the selection of short versus long course of preoperative irradiation stimulated us to review our experience. We studied this with particular reference to tumor reduction, bladder function maintenance, complications and survival.

Methods and Materials

Between January 1969, and October, 1980, a total of 52 patients completed a planned course of preoperative irradiation as follows: (A) Group I, 18 patients, received 4,500 rad in 4½ weeks followed by cystectomy 4-6 weeks later; (B) Group II, 34 patients, received 2,000 rad in one week followed by cystectomy within a week.

One patient was black while all others were white. The median age was 58 years in Group I (Range 46-76) and 64 years in Group II (Range 40-76). The male to female ratios were 3.1 to 1 in Group I and 3.8 to 1 in Group II. Seven patients had a second primary cancer (three prostate, and one case each of ureteral, renal pelvic, colonic and skin carcinoma).

A history of prior bladder tumor (three months-15 years) resected either transurethrally (TUR), by loop resection or segmental resection, was noted in about two-thirds of each group. The most common presenting symptoms listed in decreasing order of frequency were hematuria, dysuria, frequency and urinary retention. Bimanual examination was performed at the time of cystoscopy and biopsy for diagnosis. Routine tests included chest X-rays, BUN, serum creatinine determination, excretory urography, urine cytology and barium enema. Abnormal lymphangiogram, when obtained, (one positive and one equivocal) did not change the clinical stage. Pelvic and retroperitoneal CT scan did not affect the clinical stage in 23 patients while it changed the clinical stage (higher stage) in

TABLE 1

B1: Superficial muscle
B2: Deep muscle
C: Prevesical fat
D1: Adjacent organs
D2: Pelvic lymph nodes and/or attached to pelvic or abdominal wall
D3: Extrapelvic organs or juxta-regional nodes

Pathological Versus Clinical Stage

Clinical stage	No. of patients	No Tumor	A	B1	B2	C	D1	D2	D3
Group I									
B1	1			[1]					
B2	5	1		2	[1]	1			
C	7	1		2	1	[2]		1	
D1	3	1	Stage	1		1			
D2*	2		Reduction			1			1
Total	18	3	0	6	2	5	0	1	1
Group II									
B1	9	2	3	[2]				2	
B2	15	1		5	[3]	3		3	
C	9		Stage	2	1	[4]		2	
D1	1		Reduction					1	
Total	34	3	3	9	4	7	0	8	0

Squares: Patients remaining in the same stage
**Surgically staged prior to radiotherapy*

four patients with extension outside the bladder. Table 1 describes the clinical stage (Jewett, Strong, Marshall system)[6] of both groups.

Histopathologically, there were 42 patients with transitional cell carcinoma, six with neoplastic squamous differentiation in addition to transitional cell carcinoma and four with pure squamous cell carcinoma. The neoplasms were well differentiated (Grade I) in one patient, moderately differentiated (Grade II) in 11 patients and poorly differentiated (Grade III) in 40 patients. In Group I there were five patients with Grade II and 13 patients with Grade III carcinoma. In Group II there were one, six, and 27 patients with Grade I, II, and III, respectively.

Preoperative radiotherapy (4 MeV or Cobalt-60) covering the whole pelvis was delivered through anterior and posterior parallel opposed ports or occasionally by a box technique in obese patients. The mean nominal equivalent total tissue dose in Group I (1,173 ret) was higher than in Group II (850 ret).

Radical cystectomy followed the planned radiation in all patients except in four patients in each group where conservative segmental resection was performed. Cystectomy was usually one stage radical cystectomy and ileo-conduit urinary diversion. This was not the case for eight patients in Group I, in whom cystectomy followed initial diversion and preoperative irradiation.

Side Effects and Complications

Radiotherapy was well tolerated in both groups. In Group I, one patient developed transient moist skin desquamation, three developed cystitis and four reported diarrhea. There were no significant side effects in Group II patients. Three patients in Group I and six patients in Group II developed minor, surgically related, complications.

There were only two long term complications in Group I. These were corrected by subsequent surgery (lysis of abdominal adhesions and sigmoid resection for sigmoiditis). There was a single mortality (cardiovascular death) occurring 10 days after cystectomy and a short preoperative course of irradiation.

TABLE 2
Pathological versus clinical stage (summary)

	Group I 4500 rad	Group II 2000 rad
Stage reduction	61%	41%
Same clinical and pathological stage	22%	27%
Understaging	17%	32%

Pathological Staging

Table 1 shows the relationship between the clinical and pathological stages in Groups I and II. The percentages of no stage change (the same pathological and clinical stage), stage reduction (lower pathological than clinical stage) or understaging (higher pathological than clinical stage) are shown in Table 2. Post-cystectomy lower pathological stage was 61% in Group I versus 41% in Group II patients. There was no residual microscopic disease in 17% in Group I compared to 9% in Group II patients. Two patients in Group I

and eight patients in Group II were found to have lymph node metastases upon histological examination of the regional nodes. Five of the eight patients in Group II with lymph node metastases received additional pelvic irradiation for 1,500-4,500 rad in 1½ to 4½ weeks.

TABLE 4
Tumor reduction & disease free survival

	1 Year	3 Year	5 Year
Tumor Reduction 25 patients	17/17 (100%)	10/14 (71%)	5/8 (63%)
No tumor reduction 27 patients	13/18 (72%)	2/8 (25%)	1/5 (20%)

Survival

Sixty-five percent of the entire group are currently alive and free of disease with a median survival of 20 months (3-100 months). A total of 25% have died with disease and the remaining 10% are alive with disease. Eleven of 52 (21%) developed local pelvic failures.

Table 3 describes one, three, and five year actuarial disease-free survival showing no significant difference in survival among Group I and II patients. Median survival in Group I and II patients was 18 and 16 months, respectively, which is not statistically significant.

Prognostic Factors

Among patients eligible for the one, three and five year disease free survival evaluation, those with tumor reduction showed statistically significant improvement when measured by Student's test and Welch's approximation. Those without tumor reduction at surgery showed significantly less improvement. (Table 4).

Two out of three patients with invasion of the glandular tissue of the prostate died with disease while one patient with only invasion of the prostatic urethra remains free of disease seven years after therapy.

Five of eight patients with initial ureteric obstruction (unilateral or bilateral) are alive and free of disease. The remaining three patients died with disease.

The median survival of patients with Grade I and II carcinoma (12 patients) was 21 months as compared to 14 month median survival for patients with Grade III carcinoma (40 patients). This difference was statistically significant ($P < 0.05$) as measured by Student's test and Welch's approximation.

Table 5 describes the status of patients with pelvic node metastases and those who had a segmental resection.

Discussion

There is considerable interest and debate concerning the optimum dose of preoperative irradiation in bladder cancer. Doses from 2,000-5,000 rad in 1-5 weeks achieved similar success with reference to regional control and distant metastases.[9-11] Table 6 describes a wide range of biologically equivalent doses from various publications.[1,2,4,6,12] We are not aware of any random studies to settle this question. Since there is no available solid information, there will always be room for confusion and controversy.

Common radiotherapeutic rationale indicates that a preoperative dose of 4,000-5,000 rad delivered over a period of four to five weeks has a high probability of more effective local eradication of muscle invading tumors and has shown an improved five year survival rate,[9] which is higher than reported by Whitmore and associates.[6] The latter series featured such factors as field size, improved surgical technique, patient referral patterns and exclusion of patients with early metastases. These factors could conceivably cause the short lower dose preoperative regimen to seem effective as the relatively long higher dose preoperative radiation seen in the historical control.[10] A recent review article[13] concluded that patients with superficial low grade tumors do well with surgery and do not benefit from radiation therapy. However, since the current clinical staging system has grossly underestimated the final pathological stage,[2,6,9,10] one might conclude that the short lower dose would appear more suitable for clinically Staged O, A, and B1 patients. The sandwich technique[14] combining pre- and postoperative radiotherapy, was designed for such controversy. However, it is not yet popular and there are no conclusive results.

We cannot claim that our data have answered these questions entirely. Our figures showed no improved survival of Group I versus Group II patients. However, the numbers were relatively small. If one considers the fact that there were nine patients (26%) with superficial cancer (B1) in Group II, as compared to only one patient (6%) with B1 cancer in Group I, one might conclude that the long course appears more effective. Table 2 indicates a higher percentage of down staging in the long versus the short course. Such down staging was associated with a better one, three, and five year disease free survival (Table 4). These data and others[1,2,10,15,16] support the importance of pathological down staging on prognosis. Furthermore, in our series there was an enhanced tumor reduction, diminished pelvic node metastases, and a greater chance of saving bladder function among

TABLE 3
Disease free-survival

	1 Year	3 Year	5 Year
Group 1	12/14 (86%)	6/11 (55%)	4/9 (44%)
Group 2	18/21 (86%)	6/11 (55%)	2/4 (50%)
Overall	30/35 (86%)	12/22 (55%)	6/13 (46%)

TABLE 5
Status of patients with:

A. Pelvic Node Metastases
2/18 (11%) Group I (1 NED)*
8/34 (24%) Group II (4 NED)*

B. Segmental Resection
4/18 (22%) Group I (3 NED)*
4/34 (12%) Group II (3 NED)*

NED: No Evidence of Disease
**Remainder of patients are with disease*

TABLE 6
Estimated Biologically Equivalent Dose

Author	Total Dose (rads)	Fraction size	No. of Fractions	N S D	T D F
Whitmore 1977	2000/5D	400	5	1139	48
Reid 1976	2000/4D	500	4	1231	54
Werf-Messing 1971, 1973	4000/4W	200	20	1362	66
Prout 1973	4500/4W	200	23	1453	75
Miller 1977	5000/5W	200	25	1572	82

NSD: Nominal single dose; TDF: Time dose factor D = Days; W = Weeks

patients with the long versus the short course. This is probably because large doses of radiation kill more cells and permit sufficient time to allow for adequate tumor shrinkage. In addition, it could help assure resectability of large infiltrating tumors while reducing operative mortality and morbidity. With a preoperative dose of 4,000-5,000 rad/4-5 weeks, it is also possible to consider a simple or a segmental cystectomy[3] with a node sampling procedure, perhaps reducing surgical complications. The presence of pelvic lymph node metastases four to six weeks after such high dose preoperative irradiation would indicate poor prognosis and the likelihood of distant metastases. Moreover, it would be highly unlikely that lymph node dissection would eradicate such lymph node metastases.

Others[16] have attempted prompt radical cystectomy after 4,000 rad of preoperative irradiation without undue complications. This has been done to eliminate concern that the period of delay between radiotherapy and surgery might encourage tumor progression or distant metastases.

The indications for attempted preservation of bladder function should include: (1) A strong desire of the patient to preserve bladder function and sexual potency, especially in relatively young males; (2) Age, sex of patients and operative risks; (3) Preferably considered after adequate doses (4,000-5,000 rad/4-5 weeks) of preoperative irradiation to sterilize the margin of resection from microscopic disease and (4) Frequent future cystoscopies to detect early recurrence and to consider a salvage cystectomy.[17,18]

Our data and others failed to show any evidence of increased morbidity or mortality as the result of relatively large doses of preoperative irradiation.[6,12,19] Eight out of 18 patients in Group I were treated by post diversion, precystectomy and preoperative radiation with no mortality and a 13% complication rate (one patient). Others have shown similar experiences[20-24] with good local control and a reasonable five year survival rate. The advantages of such a technique include accurate staging, diminished surgical trauma (two stage operation) and fewer anastomotic problems. The technique omits radical node dissection and might spare the occasional patient with Stage D2 and D3 disease a radical cystectomy. Disadvantages include a second operative procedure, resulting in a loss of income and added medical expense.

Conclusion

The advantages and disadvantages of short and long preoperative courses of irradiation have been discussed. There is a need for large scale randomized studies to further clarify the optimum dose of preoperative irradiation in bladder cancer. ◀

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A complete list of references for "Preoperative Radiation Therapy in Cancer of the Urinary Bladder: The Short Versus the Long Course," may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago IL 60603.

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Use of Ultrasound

Two Cases of Combined Intrauterine and Extrauterine Pregnancy

By John J. Paterson, M.D./Freeport

Two cases of ectopic pregnancy are presented. Clinical findings mandated surgical intervention although an intrauterine pregnancy was identified pre-operatively by ultrasound.

Ultrasound has become a useful and common tool in the diagnosis of ectopic pregnancy. Kobayashi's[1] criteria for the diagnosis of ectopic pregnancy included the absence of intrauterine pregnancy. Stocker[2] stated that ultrasonography can enhance the clinical picture in suspected ectopic gestation by visualization of an empty uterus and small adjacent mass. Haney[3] stated that the most common sonographic finding in ectopic pregnancy is a slightly enlarged, empty uterus, with or without a complex pelvic mass.

Case 1

A 25 year old Gravida II, Para I, female presented to the emergency room complaining of severe abdominal pain with radiation to the right shoulder since the evening prior to admission. Her last menstrual period had begun 10 weeks earlier. A positive urine pregnancy test had been obtained one month after that time and a small amount of vaginal spotting had been noted just two weeks ago. Three days prior to admission she had been evaluated for abdominal pain.

Neither peritoneal irritation nor masses (other than an 8-9 week sized uterus) were noted. Urinalysis at that time was unremarkable.

Significant history included: (1) normal delivery, 2296 gm. infant, seven years before; (2) D&C showing secretory endometrium four years later; (3) treatment for 'PID' with IUD ten months after D&C; (4) left salpingo-oophorectomy, right fimbrioplasty and lysis of adhesions three months after that; (5) diagnostic laproscopy showing right tube patency fourteen months later and (6) hysterosalpingogram showing spillage just two months ago.

Pertinent physical findings showed the patient was afebrile, P = 120, BP = 130/70, R = 30, Hb. = 11.2 gm.%, WBC = 11,800 and U.A. = WNL. The abdomen was distended and bowel sounds were present. There was generalized guarding with rebound tenderness. No palpable organomegaly was noted. Vaginal exam revealed no bleeding. The cervix had a normal appearance and was tender to motion. The uterus was not well examined secondary to the abdominal tenderness. No adnexae masses were felt.

Ultrasound showed an intrauterine gestational sac measuring 38mm (compatible with menstrual age 7-8 weeks). Exploratory laparotomy shortly after admission found a right ruptured tubal pregnancy and a uterus compatible with an eight week intrauterine pregnancy. Postoperatively, the patient received routine prenatal care, good uterine growth was noted and patient delivered a full term 3430gm. infant vaginally without complications.

Case 2

A 27 year old Gravida III, Para II presented to the emergency room complaining of vaginal spotting and lower abdominal pain. Her last menstrual period had begun eight weeks before. An IUD was removed after a positive pregnancy test had been obtained.

History included a first pregnancy without apparent complications and a normal vaginal delivery. The



Figure 1

second pregnancy had presented at term as an incomplete breech and was delivered by cesarean. Between the two pregnancies, the patient had undergone a pre-sacral neurectomy for pelvic pain.

Pertinent physical findings showed the patient afebrile, P = 84, R = 16, and BP = 122/84. The abdominal exam was normal. Vaginal exam revealed a uterus compatible with eight weeks gestation and a 5cm. cystic, non-tender, left adnexae mass.

Ultrasound the morning after admission (see Figure 1) showed an intrauterine pregnancy estimated at 7-8 weeks gestation. About 24 hours after admission the pain increased. The previously non-tender mass (a presumed corpus luteum cyst) was now very tender. A diagnosis of torsion of a corpus luteum cyst was made and exploratory laparotomy performed. A left tubal pregnancy was found and a uterus compatible with 8 weeks gestation identified. Post-operatively, her course was unremarkable except for a small amount of vaginal bleeding. Office follow up care noted a decrease in uterine size and spontaneous menses resumed two months later.

Summary

Combined intra- and extrauterine pregnancies are rare occurrences, but well reported ones.[4,5] Ultrasound is touted as a diagnostic aid to differentiating an intrauterine and ectopic pregnancy. Cases of combined intrauterine and ectopic pregnancies should not be evaluated using the usual ultrasound criteria for ectopic pregnancy alone.

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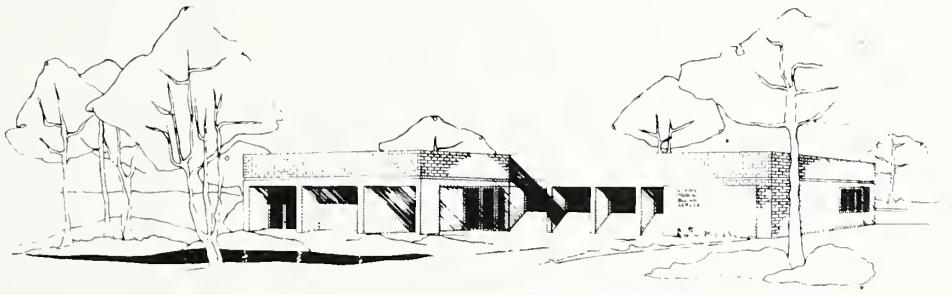
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Muscle Syndromes—Part I:

Polymyalgia Rheumatica

A 62 year old physician was seen for thigh and shoulder pain. He had noted sudden onset of pain in both hips associated with marked stiffness four weeks before. Bilateral shoulder symptoms soon followed. Mornings were described as the worst time: he could barely arise from bed, and required his wife's help in putting his extremities into shirts and trousers. Bending to tie his shoes was impossible. Toward noon, he would note improved mobility. Weakness seemed a prominent feature, and he fatigued easily. Neck and lumbar pain was denied, as was pain in other peripheral joints. Ibuprofen had afforded some relief.

There was no rheumatic history other than occasional knee stiffness. He denied headaches, visual changes, or jaw claudication. He noted no difficulty in swallowing. There was no rash. Fever was not present, but he had lost seven pounds despite an adequate appetite. He denied depression. Other than ibuprofen, he was on no medications. Besides an old basal cell carcinoma removed from his face years ago, other history and review of systems was unremarkable.

On examination, he was afebrile. Positive findings were confined to the musculoskeletal system where severe pain but normal range of motion were noted in hip and shoulder girdle. Heberden's nodes were observed at the DIP joints of the hands, and a small effusion was present in the left knee. Other joint exam was unremarkable. Neurological exam was intact; relaxation of reflexes was not delayed. On motor exam, proximal muscle weakness was not demonstrated. Temporal artery pulses were present and not tender to palpation.

Laboratory

SMA-18, complete blood count, urinalysis, EKG and CXR were unremarkable. Westergren sedimentation rate was 73mm/hr. Rheumatoid factor, antinuclear antibodies and complement levels were normal. CPK, aldolase and thyroid function tests were also normal. X-rays of shoulders and hips were unrevealing; knee X-rays revealed moderate degenerative arthritis. Fluid aspirate from the left knee showed clear yellow fluid with normal viscosity; no crystals were noted. WBC count was 1,100/hpf with 20% polymorphs; gram stain and culture were negative.

Discussion

Sudden onset of bilateral and symmetric pelvic and shoulder girdle aching and stiffness in the elderly is the typical clinical presentation of polymyalgia rheumatica (PMR).[1,2] The sensation is one of overused, stiff, aching muscles, as if one had shoveled snow the day before. Morning stiffness and gelling of a type found in inflammatory arthritis is often a part of this syndrome, as is improvement with use as the day progresses. Stiffness may be so severe that normal mobility is impaired, and rarely may be so severe that the patient may be bedridden. Muscle weakness is a common complaint, and in a proximal distribution may suggest polymyositis. Careful examination, however, reveals no objective weakness, and laboratory measurements of muscle inflammation such as elevated CPK, abnormal EMG and abnormal muscle biopsy are not present. The cause of muscle symptoms in this syndrome remains unclear. Although synovitis may be present in PMR (most often in knees and wrists with carpal tunnel a common feature), it cannot be consistently shown to exist in hips and shoulders of symptomatic patients. In general, the more objective synovitis reported, the greater diagnostic likelihood of rheumatoid arthritis rather than PMR.

Patients are usually over 55 years of age (and often older) and male/female ratios approximate each other. Constitutional symptoms are a prominent feature of the illness. Weight loss, malaise, fever, anorexia and apathy often coexist. In the elderly, these may suggest depression, hypothyroidism, systemic infection or an underlying malignancy. The hallmark of PMR is an elevated sedimentation rate, usually over 50 but often approaching 100, although rare cases with lower sedimentation rates have been noted. A nonspecific anemia of chronic illness may be present, as may an elevated globulin. Autoantibodies

are usually absent. Occasionally, an elevated alkaline phosphatase is present representing mild hepatic inflammation.

Therapy may be begun with nonsteroidal antiinflammatory agents such as aspirin, and may be adequate to control symptoms in up to 20% of patients. Most patients, however, will respond dramatically and completely to prednisone in doses of 10 to 15mg per day, often with a corresponding decrease in sedimentation rate and resolution of anemia. Subsequently, prednisone may be tapered to the lowest effective dose using sedimentation rate and clinical symptoms as a guide. These admonishments pertain: every other day medication often fails and the disease may persist for two years or more, necessitating long-term therapy. Persistent elevation in sedimentation rate despite low dose prednisone, or resistance of symptoms to such therapy, should suggest another diagnosis or the undisclosed presence of giant-cell arteritis (GCA).

Association of Temporal Arteritis

The clinical association of GCA (temporal arteritis) with PMR is now well recognized, but the pathologic and etiologic associations remain unclear. GCA[3,4] is a granulomatous inflammatory vasculitis of large "named" arteries of the extracranial vessels and, less often, intracranial or systemic vessels. Cause, as in PMR, remains unknown. Age and sex ratios are the same. Signs and symptoms result from vascular spasm, occlusion or obstruction and are most often referrable to the extracranial vessels. Headache is the most common and constant complaint. Usually bitemporal, it may be diffuse and any new headache in the elderly is suspect. Scalp pain may be present over the temporal arteries, and decreased or absent pulses accompanied by bruits, nodules or skin ulcerations may be noted. Acute blindness may occur, may rarely be the presenting symptom, and results from ophthalmic or central retinal vessel disease. Loss of vision may be transient or permanent, partial or complete, and may be associated with normal fundoscopic exam. Transient diplopia may herald the more severe eye complications. Any acute visual change in the elderly must raise the suspicion of GCA and instigate appropriate measures for diagnosis and therapy. Another common complaint includes claudication of the tongue or muscles of mastication during eating or talking. Jaw pain, trismus, or lingular blanching or infarcts may result. Systemic vessels[5] may be involved in up to 10% of patients and include aortic dissection; brachial artery disease with bruits, Raynaud's or gangrene; and renal artery disease. Rarely, intracranial vessels have been noted to be involved.

Constitutional symptoms often accompany GCA, and PMR-like symptoms may precede or coexist. Rare patients may present with only fever and the diagnosis should be included in elderly patients with FUO. The laboratory hallmark of illness, as with PMR, is an elevated sedimentation rate which often approaches 100. Rarely, the sedimentation rate may be normal. Diagnosis is made by typical changes on biopsy of the preauricular superficial temporal artery. "Skip" areas of disease have been noted, so multiple cuts of the vessel must be analysed by the pathologist, and occasionally the contralateral vessel should be biopsied. Therapy is with prednisone, initially 60 to 100mg/d. In GCA, the sedimentation rate accurately reflects activity of disease, and medication should be tapered with an eye to keeping it in the normal range. Cytotoxic agents have been substituted or used as an adjunct in chronic therapy when doses of prednisone needed to control disease are unacceptable or toxic.

The clinical association between PMR and GCA bears further analysis. Up to 50% of patients with symptomatic GCA have PMR-like muscular symptoms. Of more importance, 10-40% of patients with PMR can be demonstrated to have silent GCA when preauricular temporal artery biopsies are done. Should all such PMR patients have the artery biopsied? Rheumatologists disagree: some feel it is worthwhile to uncover the hidden GCA while others await a failure of low dose prednisone to control PMR or sedimentation rate before pursuing a biopsy. Certainly, in veiw of the difference in prednisone changes needed to treat PMR and GCA, and the potential serious consequences of GCA, one must constantly be vigilant in the PMR patient in terms of suspicion of GCA's silent existence.

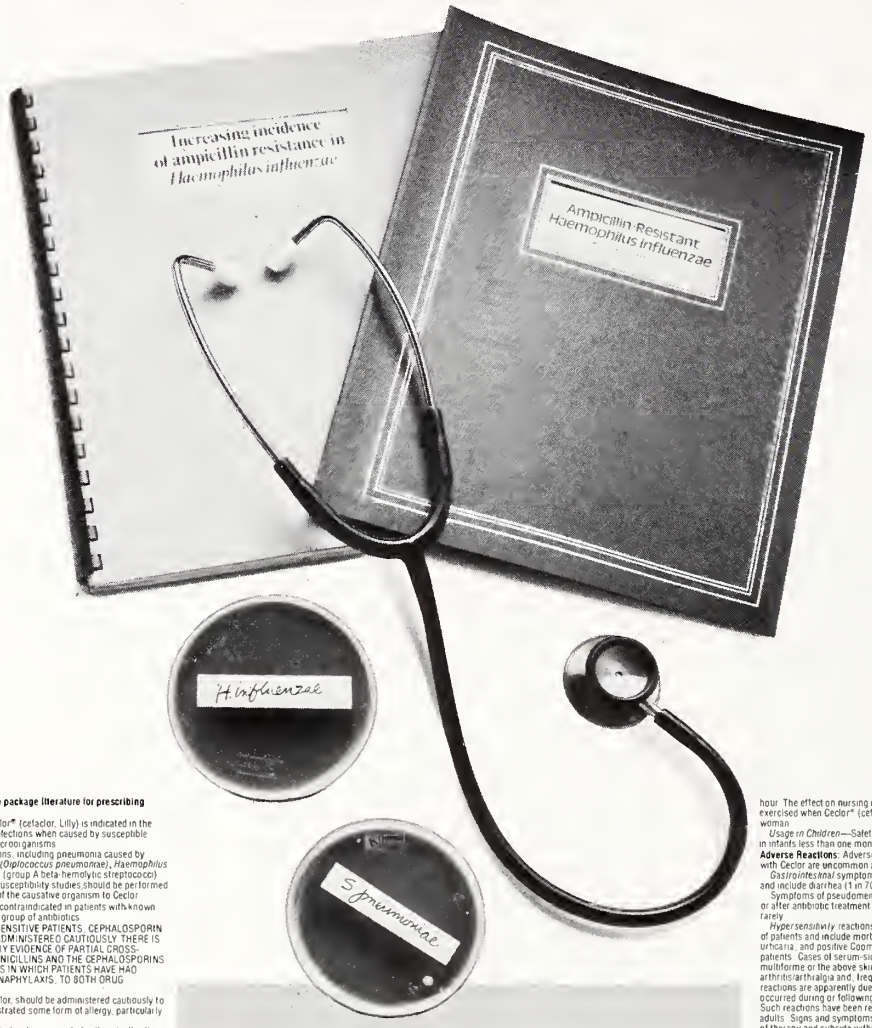
Conclusion

Bilateral hip and shoulder girdle aching and stiffness associated with an elevated sedimentation rate in this 62 year old seemed best explained by PMR. The absence of synovitis (except in his osteoarthritic knee) or muscle weakness seemed to mitigate against other inflammatory joint or muscle disease, as did his normal muscle enzymes and absence of autoantibodies. Preauricular temporal artery biopsy revealed no GCA. The patient was begun on 10mg of prednisone per day with good immediate relief and complete resolution of symptoms within two weeks. At one month, sedimentation rate was reduced to 23mm/hr. Over the last 10 months, his dose of prednisone has been tapered to 5mg per day (a decrease of 1mg every other month) with no exacerbation of sedimentation rate or symptoms. ◀

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Brief Summary Consult the package literature for prescribing information.

Indications and Usage. Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip; USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Registration and Education

Medical Disciplinary Board

The following orders have been received from the Department of Registration and Education regarding the discipline of physicians:

- *Frederick J. Sloan, M.D.* The probationary status placed on the license of Dr. Sloan (license # 36-29227) was reversed by court order on December 7, 1983, and his license is now in good standing.
- *Antonio C. Camacho, M.D.* Schedule II of the controlled substance license of Dr. Camacho (license # 036-046846) was suspended on December 27, 1983, while Schedules III, IV, & V were restored pending a final disposition of his case.
- *William McNabola, M.D.* On January 9, 1984, the Department of Registration and Education restored the license to prescribe controlled substances of William McNabola, M.D. (License # 003-31579.)
- *William Farley, M.D.* On January 9, 1984, the Department of Registration and Education restored the controlled substance license of Dr. William Farley (license # 003-26480.)
- *Javier Moreno, M.D.* On January 9, 1984, the Department of Registration and Education ordered the complaint against Dr. Moreno (license # 036-05232) withdrawn and his license remains in good standing.
- *Moon Hae Pak, M.D.* On January 9, 1984, the license of Dr. Pak (license # 036-059981) was reprimanded.
- *Benjamin Lee, M.D.* On January 19, 1984, the license of Dr. Lee (license # 036-40846) was placed on probation for a period of three years, during which the physician cannot practice medicine without the approval of the Medical Disciplinary Board and cannot apply for a controlled substance license until after the probation period.
- *Frank O. Becker, M.D.* On January 27, 1984, the license of Dr. Becker (license # 036-35667) was suspended and then immediately restored to good standing.
- *Frank Swiatek, M.D.* Effective January 24, 1984, the license of Dr. Swiatek (license # 36-019709) was suspended indefinitely and his controlled substance license (#003-036-019709-01) was also suspended indefinitely.
- *Warren G. McPherson, M.D.* On February 16, 1984, the medical license of Dr. McPherson was restored. However, his controlled substance license (#003-036-32374) was not restored.
- *Michael Peter Fry, M.D.* On February 16, 1984, the medical license of Dr. Fry (#36-47210) was revoked.
- *Irving Weissman, M.D.* On February 29, 1984, the medical license of Dr. Weissman (#36-27439) was suspended for one year.

(Source: Final orders of the Director of Registration and Education)

Drug Inventory Records

- Under Federal Controlled Substances regulations, a physician must take a biennial inventory of all controlled substances on hand if he is required to keep records.
- The physician who only *prescribes* or *administers* narcotic controlled substances in Schedules II-V in the lawful course of his professional practice *does not* have to take any inventory. If he *dispenses* these drugs, he *must* take the biennial count.
- The physician does not have to maintain records when he dispenses non-narcotic controlled substances listed in Schedules II-V, unless he regularly charges his patients, either separately or together with charges for other professional services, for such substances so dispensed.
- The biennial inventory (which is to be maintained with other controlled substances records by the practitioner for a two-year period) was first required on May 1, 1971 and then every two years thereafter. Persons who became registered after May 1, 1971, if required, should take an inventory on the date the physician first engaged in dispensing of controlled substances. In the event a person commences business with no controlled substances on hand, he/she is to record this fact as the initial inventory.
- The Department advises that while Federal recordkeeping requirements delineate those physicians who must maintain the biennial inventory, all practitioners must comply with the more restrictive recordkeeping requirements of the State Controlled Substances Act and the rules implementing that law.
- For more details of the biennial inventory and recordkeeping requirements, contact Mr. Lawrence Slotnik, Drug Compliance Coordinator, at the office of the Department of Registration and Education, 17 N. State, 17th floor, Chicago, IL 60602, 312-793-8573.

(Source: Correspondence from Mr. Slotnik's office)

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EKG

(Continued from page 249)

Answers: I. C, D, E 2. E

The twelve lead ECG shows a bradycardia of approximately 46 beats per minute in the first half and a rate of 60 beats per minute in the last portion. No P waves are conducted until the last panels ($V_4V_5V_6$). The black bars in lead II and V_5 mark visible P waves. This represents sinus node failure caused by sino-atrial block or sinus arrest. When the sinus fails, a slower subsidiary pacemaker takes over. This pacemaker is probably a junctional pacemaker conducting with some aberrant intraventricular conduction although an idioventricular rhythm could not be entirely ruled out. The tall R waves seen in leads II, III, and AVF are most likely caused by aberrancy rather than ventricular hypertrophy. The beats in the last column ($V_4V_5V_6$) show the sinus can capture the ventricles when the sinus fires so there is no atrioventricular block. The atrioventricular dissociation occurs because of marked sinus slowing allowing the appearance of a subsidiary pacemaker. With a history of atrial flutter in the past and sinus node failure now, this could be an example of the sick sinus syndrome. On the other hand, this could also be caused by digitalis toxicity. The recent addition of quinidine to his treatment plan makes this more likely. The addition of quinidine to digoxin in a treatment plan is well known to cause an elevation in the serum digoxin level and this may cause digitalis toxicity. The recent onset of angina pectoris with exercise plus nocturnal angina make a diagnosis of unstable angina. Digoxin and quinidine were discontinued and sinus rhythm returned. A coronary angiogram showed severe obstructions in the left anterior descending and left circumflex coronary arteries. An aorta coronary bypass surgery was recommended. Digoxin was later restarted without quinidine. ◂

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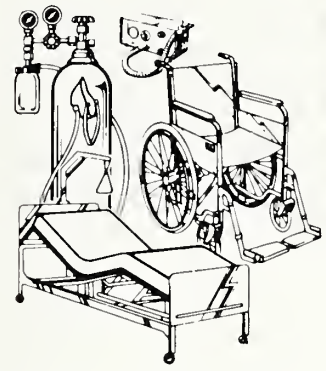
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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510 Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MAY

Cardiac Rehabilitation

7th Annual Symposium: Cardiac Rehabilitation—Update 1984
For: MD's, Nurses, Therapists, Allied Health Prof. Symposium, May 1-4, Milwaukee, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 28; UW-Extension CEU's, 28. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Diabetes

Diagnosis and Treatment of Non-Insulin Dependent Diabetes
For: MD's, RN's, RD's, Med. Students. Seminar, May 3, 12:30-5pm., Springfield. **Sponsor:** Springfield Clinic, 1025 S. Seventh St., Springfield 62708-3746. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 4 hours. **Contact:** Betty Green, R.N. **Phone:** 217-528-7541

Neuroradiology

1984 Neuroradiology Review Course
For: Radiologists, Neuroradiologists, Neurosurgeons, Residents. Course, May 5-6, Oak Brook, Illinois. **Sponsor:** Loyola University Medical Center CME and Section of Neuroradiology, 2160 S. First Ave., Maywood 60153. **Fee:** $140 MD's; $80 Res. **Credit:** Category 1, 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** 312-531-3237

Medical Education

Teaching Clinical Competence
For: MD's. Workshop, May 7-8, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, TBA. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711

Diagnosis and Treatment of Clinical Performance Problems
For: MD's. Workshop, May 9-10, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, TBA. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711

Surgery

Advances in Surgery
For: General and Specializing Surgeons. Lecture, May 7-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $420. **Reg. Limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

The Development and Current Concepts of Gastrinoma Syndrome
For: MD's. Lecture, May 9, 2-4pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215.

An Overview of Surgical Oncology
For: General Surgeons. Symposium, May 9-11, Chicago. **Sponsor:** University of Illinois at Chicago, c/o Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $250 MD's; $150 Res. **Reg. Limit:** 300. **Credit:** Category 1, 19 hours. **Contact:** Lloyd M. Nyhus, M.D., **Phone:** 312-996-6765

Cardiology

Critical Cardiac Care
For: MD's, Office Staff. Symposium, May 10, 1-5:15pm, Flora, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed. D. **Phone:** 217-782-7711

Pathology

Annual Slide Seminar: Problems in GI and Endoscopic Biopsies
For: Pathologists and Clinical Chemists. Symposium, May 14, 7pm, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, M.D., S.C. **Phone:** 312/626-4300, Ext. 5720

Morphologic Approach to Blood Disorders
For: Pathologists. Lecture, May 14-18, 8am-5pm, Chicago. **Sponsor:** American Society for Clinical Pathologists, 2100 W. Harrison, Chicago 60612. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, 32 hours. **Contact:** Linda Mays. **Phone:** 312/738-1336

OB/GYN

Specialty Review in Obstetrics and Gynecology
For: Obstetricians and Gynecologists. Lecture, May 14-19, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480. **Reg. Limit:** TBA. **Credit:** Category 1, 48 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Dysfunctional Uterine Bleeding and Evaluation and Treatment of Infertility
For: MD's, Office Staff. Symposium, May 24, 1-5:20pm, Pinckneyville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711

Radiology

Nuclear Magnetic Resonance, Computer Tomography, and Digital Radiography
For: Radiologists: Med. Physicists. Conference, May 15-18, Chicago. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, 25 hours, UW-Extension CEUs, 25 **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Internal Medicine

11th Annual Internal Medicine Symposium
For: MD's, Office Staff. Symposium, May 17-18, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed: TBA. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

45th Theodor Lang May Day Clinic
For: MD's. Lectures, Workshops, May 18-19, Rockford. **Sponsor:** St. Anthony Hospital Medical Center, 5666 East State Street, c/o Medical Education, Rockford 61108. **Fee:** $100. **Reg. Limit:** 400. **Credit:** Category 1, 12 hours. **Contact:** Betty Neogel. **Phone:** 815-226-2000, Ext. 5190

Internal Medicine

Hemorrhagic Complications of Disease
For: MD's, RN's, Technologists. Conference, May 31-June 1, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $160 MD's; $125 Others. **Reg. Limit:** None. **Credit:** Category 1, 12 hours; UW-Extension CEU's, 12 hours; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Clinical Medicine

Computers and Clinical Medicine
For: MD's, Office Staff. Symposium, May 15, 7pm-10pm, Effingham, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $30. **Reg. Limit:** None. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Psychiatry

Comprehensive Psychiatry Review, Part II; The Psychiatric Interview
For: Psychiatrists. Course, May 18-20, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago 60637. **Fee:** $325. **Reg. Limit:** None. **Credit:** Category 1, 17 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Neurology

Stroke: Diagnosis, Prevention, Treatment
For: MD's. Lecture: May 19, 8am-1pm, Urbana, Illinois. **Sponsor:** Carle Foundation Hospital, Department of Medical Education, 611 W. Park St., Urbana 61801. **Fee:** $35 **Reg. Limit:** TBA. **Credit:** Category 1, 4.5 hours, AAFP Elective, 4.5. **Contact:** Deborah C. Rugg. **Phone:** 217-337-3022

Practice Management

Choosing and Using a Computer in Private Medical Practice
For: MD's. Lecture, May 25-26 8am-5pm, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $295. **Reg. Limit:** None. **Credit:** AMA Category 1, 16 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215

Family Medicine

Specialty Review in Family Practice
For: GP's, FP's. Lecture, May 29-June 9, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Reg. Limit:** 90. **Credit:** Category 1, 91 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-733-2800

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MD's. Lecture, May 29, 4:30pm-6:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, M.D. **Phone:** 312-578-3215

JUNE

Gastroenterology

Inflammatory Bowel Disease: Current Concepts in Diagnosis and Management

For: MD's, RN's, LPN's. Symposium, June 1, 8am-5pm, Springfield Hilton. **Sponsor:** Springfield Clinic, 1025 S. Seventh St., Springfield 62708-3746. **Fee:** $25 **Credit:** Category 1, 8 hours. **Contact:** Ernesto B. Eusebio, M.D. **Phone:** 217-525-4524

Stress Management and Relaxation Skills

Teaching Stress Management and Relaxation Skills

For: MD's, RN's, Health Care Prof. Workshop, June 3-8, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AACN. 3.5 CEU's.

Pain Management

Management of Pain

For: MD's, Office Staff. Symposium, June 6, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P O Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Suicide Intervention

For: Health Professionals. Workshop, June 7, Green Bay Wisconsin; June 8, Wausau, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $55. **Reg Limit:** None. **Credit:** Category 1, 6 hours; UW-Extension CEU's, 6. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

OB/GYN and Neonatal/Perinatal

Obstetric and Neonatal Aspects of Infant Respiratory Distress Syndrome

For: MD's, RN's, Resp. Therapists. Conference, Workshops, June 7-8, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $210, MD's; $140, Other. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; UW-Extension CEU's, 13. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Cardiology

Advanced Cardiovascular Diagnosis and Therapy

For: MD's. Seminar, June 7-9, 8am-5pm, Westin Hotel, Chicago. **Sponsor:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. **Fee:** $295. **Reg. Limit:** 85. **Credit:** Category 1, 18 hours; AAFP Prescribed, 18 hours. **Contact:** Doris Price. **Phone:** 800-525-8651, Ext. 123

Nephrology/Renal

Clinical Approach to Arterial Blood Gases and Electrolytes

For: MD's. Course, June 8-9, Peoria. **Sponsor:** American College of Physicians, Postgraduate Division, 4200 Pine St., Philadelphia, Pennsylvania 19104. **Fee:** ACP Members, FACP, Res., Research Fellows, $165; Non-Members $240; ACP Assoc., $130. **Reg. Limit:** 200. **Credit:** Category 1, 12 hours. **Contact:** Maxine Topping. **Phone:** 215-243-1200

Orthopedics

Specialty Review in Orthopedics

For: Orthopedic Surgeons. Lecture, June 10-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** TBA. **Credit:** Category 1, 66 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600.

Pathology

Surgical Bleeding Problems: Anticoagulant Monitoring

For: Pathologists, Clinical Chemists. Symposium, June 11, 7pm, Drake Hotel, Chicago. **Sponsor:** Chicago Pathological Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall H. Short, M.D., S.C. **Phone:** 312-626-4300, Ext. 5720

Surgery

Oncology Symposium

For: MD's, RN's. Lecture, June 11, Sangamo Club. **Sponsor:** Springfield Clinic, 1025 S. Seventh St., Springfield 62708-3746. **Fee:** None. **Reg. Limit:** 60. **Credit:** Category 1, 1.5 hours. **Contact:** Ernesto B. Eusebio, M.D. **Phone:** 217-525-4524.

Industrial Fitness

For: MD's, RN's, Allied Health Professionals. Workshop, June 11-15, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 450. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

Cardiac Rehabilitation

Cardiac Rehabilitation Workshop

For: MD's, RN's, Allied Health Professionals. Workshop, June 11-15, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours, AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

OB/GYN

Fifth Annual Chicago Area Schools of Medicine Review Course in Obstetrics and Gynecology

For: Gynecologists. Course, June 11-16, Chicago. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago 60637. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 36 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Weight Control

Weight Control Workshop

For: MD's, RN's, Allied Health Professionals. Workshop, June 18-22, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's.

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences

For: MD's. Lecture, June 26, 4:30-6:30pm. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Pediatrics

For: Pediatric Hematologists & Oncologists. Lecture, June 27-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $310. **Reg. Limit:** 90. **Credit:** Category 1, 24 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600.

JULY

Family Medicine

Symposium on Computers

For: MD's, RN's, LPN's. Symposium, July 2, 6:30pm, Sangamo Club. **Sponsor:** Springfield Clinic, 1025 S. Seventh St., Springfield 62708-3746. **Fee:** None. **Reg. Limit:** 60. **Credit:** Category 1, 1.5 hours. **Contact:** Ernesto B. Eusebio, M.D. **Phone:** 217-525-4524.

Risk Factor Management

For: MD's, RN's, Allied Health Professionals. Workshop, July 9-13, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit. Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

Cardiac Rehabilitation

Cardiac Rehabilitation Workshop

For: MD's, RN's, Allied Health Professionals. Workshop, July 9-13, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

Weight Control

Weight Control Workshop

For: MD's, RN's, Allied Health Professionals. Workshop, July 16-20, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN; 3.5 CEU's.

Emergency Medicine

Fourth Annual Common Emergency Care Problems

For: MD's, RN's, Allied Health Professional. Conference, Workshops, July 19-20, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences

For: MD's. Lecture, July 31, 6:30pm, North Chicago. **Sponsor:** University Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

A double blind study evaluated oral tablets of bismuth subsalicylate as a prophylactic and as a therapeutic agent in diarrheas secondary to *Escherischia coli.* Both tablets and liquid forms of this preparation when administered in 600mgm dose eight hours and two hours before exposure to *E. coli.* then two hours and four hours after exposure and finally q.i.d. thereafter for three days, reduced the incidence of "travelers diarrhea" in healthy volunteers. Recovery testing of *E. coli* revealed its effect to be a reduction in the multiplication of *E. coli.* The value of bismuth subsalicylate as a therapeutic agent was not confirmed. Additional studies are suggested by the authors. (Graham, D., *et al: Gastroenterology* 85:1017-22, 1983)

The Mayo Clinic medical records were reviewed for the years 1950-1954 and subsequently between 1975-1979 for the incidences of myocardial infarcts, sudden unexpected death and cerebral infarction. The incidence of cerebral infarction appeared to decline by 55% over that period, whereas the incidence of myocardial infarction declined by 14%, and the incidence of sudden unexpected death declined by 30%. The authors believe that improved anti-hypertensive regimens may have a greater beneficial effect on the cerebral vessels than on the coronary vessels. The other risk factors may play a greater role in coronary vessels than on the cerebral vessels. (Garraway, W. *et al: The Lancet* 2#8363:1332-35, Dec 10, 1983)

Physicians suspecting congenital anomalies may use ultrasonography between the sixteenth and eighteenth weeks of gestation. Use has expanded from the initial efforts in placental localization, abdominal circumference, intrauterine volume and fetal urine production, to antenatal detection of fetal anomalies. Approximately 150,000 children born annually (or 3-5% or all live births), have congenital anomalies. Early detection may permit better counseling and forewarn obstretricians and neonatologists. (Hill, L. *et al: Mayo Clin Proc* 58:805, 1983)

Low back syndromes are common complaints following recreational and athletic activities. They may be classified as visceral, vascular, neurologic and spondylogenic. The most common mechanical causes within the last group are muscle strain, "kissing spines," and leg length disrepancies. Some more serious sources to be considered are disc herniation, Scheuermann's disease (swimmer's back), compression fractures of the vertebral bodies, and stress fractures of the posterior elements of the vertebrae. Most compression fractures heal without complications, but chronic vertebral instability with pain and disability as well as genitourinary tract dysfunction can result. (Keene, J.: *Post Grad Med* 74:6,209, Dec 1983)

Bacteriurea occurred post-operatively in 28 patients after transurethral prostatectomy in 122 cases. Staph epidermidis infections responded to removal of the catheter but other infections tended to persist. Catheter-urine counts of greater than 10^3cfu/ml (or possibly less) indicate significant urinary tract infections and warrant antimicrobial therapy after catheter removal subsequent to prostatectomy. (Gordon, D.L., *et al: The Lancet* 2#8362,1269-71 Dec 3 1983)

Diurnal variations in prednisolone medication in six patients were evaluated. Prednisolone was administered at 6:00 am, noon, 6:00 pm and midnight for bioavailability. The 6:00 am dose appeared to have the greatest bioavailability with the least suppression of the hypothalamic-pituitary-adrenal function and exhibited the least toxicity. (English, J., *et al: Clinical Pharmacol Ther.* 33:381-85, 1983)

Severe reflex sympathetic dystrophies were treated by intravenous guanethidine in 19 patients. This was found to be more effective than repeated stellate ganglion blocks. Guanethidine injections every fourth day for four consecutive sessions gave relief equal to stellate ganglion blocks each second day for a total of eight blocks. (Bonelli, S., *et al: Pain* 16:297-307, 1983)

The FDA Drug Bulletin has reported major human birth defects and spontaneous abortions in pregnant women taking isotretinoin. A Vitamin A isomer that is terratogenic, it is short acting, and should be discontinued at least one month before conception. Additional side effects reported have been pseudotumor cerebri with intracranial hypertension, papilledema, retinal hemorrhages, hyperuricemia, regional ileitis, and corneal opacities. (*FDA Drug Bull.* 13#3,21-2, Nov 1983)

Sequential cortical diameters of the metacarpals were measured by radiographic morphometry in 120 normal postmenopausal women. These patients were treated with ethinyl estradiol in doses ranging from 5-50μg daily. There was a net loss of bone at doses of 15μg per day or less, a net gain at doses of 25μg per day and at doses between these two, neither loss nor gain. In post-menopausal women, the cortical bone changes were related to the estrogen dosage. (Horseman, A: *N Engl J Med.* 309:1405-7, Dec 1983)

The Assistant Secretary's Advisory on Treatment of Mild Hypertension suggests that mild hypertensions in the range of 90-94mmHg diastolic pressure be treated by nonpharmacologic measures first to bring the diastolic pressure down. It further recommends that the lowest doses be used for any drug. Diuretics of greater than 50mgm daily of hydrochlorothiazide should not be exceeded. In patients with abnormal resting ECG additional antihypertensive drugs may be warranted if 50mgm of hydrochlorothiazides are ineffective in controlling the hypertension. Appropriate monitoring of serum potassium levels is necessary. (*FDA Drug Bull* 13#3,24-5, Nov 1983)

Ten insulin dependent diabetics with average age of 29 years and mild hypertension were followed for 39 months. During this period they were evaluated for diabetic nephropathy. During the initial 29 months they did not receive antihypertensive medications and they showed a progressive albuminuria. Upon treatment with antihypertensive medications as well as their insulin, the albuminurea decreased, the glomerular filtration rate decreased from 0.91/ml/min to 0.39ml/min. The arterial BP decreased from an average 144/97mmHg to 128/84. Hypertension enhances the development of diabetic nephropathy, and thus may lead to renal failure and death. (Parving, H., *et al: The Lancet* 1175-9, 1983)

The incidence of peptic ulcers in a control population was 0.8% whereas peptic ulcer was found in 1.8% of patients receiving corticosteroids for even less than 30 days. Gastrointestinal hemorrhage occurred in 1.6% of a control group as contrasted to 2.5% of patients treated with corticosteroids. Corticosteroids thus increase the incidence of peptic ulcer and GI hemorrhage although the treatment is given for less than 30 days in doses of less than 1,000mg of prednisone-equivalent doses. (Messer, J. *et al: N Engl J Med.* 309:21-4, 1983)

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago IL 60603.

BEARDSTOWN:
Population of 7,000 with a service area of 30,000. Located 45 miles from Springfield. Under contract management of Memorial Medical Center. New three person medical office building. First year guaranteed income plus other benefits. Recreational facilities nearby. CONTACT: Jeffrey L. Martin, P. O. Box 350, Beardstown 62618. (217) 323-2720. (4)

DU QUOIN.
Orthopedic surgeon needed for clinic and surgical services. Fully equipped office adjacent to X-ray and emergency. Complete support services in house. Excellent opportunity in rural medicine. 20 miles from SIU-Carbondale. Beautiful community 70 miles southeast of St. Louis. David R. Hosler, Administrator, Marshall Browning Hospital, Du Quoin 62832, 618-542-2146. (4)

GIBSON CITY:
Internist/Cardiologist—Excellent opportunity in East Central Illinois; modern, well equipped hospital, sophisticated ICU, attached private SNF: new professional office space and incentives available; rural community within 30 minutes of major university, tertiary care center, metropolitan area with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City 60936. 217-784-4251. (8)

GLEN ELLYN:
Internist to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. Contact: Dave Bauer, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave. Glen Ellyn 60137, 312-469-9200. (5)

KEWANEE:
Population 16,000. Opportunities in Urology, Orthopedics, and Family Practice (solo or associate). One-hundred fifty miles from Chicago, between Peoria and the Quad Cities. Assistance in establishing practice available. Contact: William H. Thieben or Glenn A. Doyle at Kewanee Public Hospital, 719 Elliott Street, Kewanee, Illinois 61443. (8)

MATTOON:
Primary care physicians needed for tri-county clinic. Attractive East Central Illinois community. Financial startup package. Access to university towns. Anesthesiologists needed for six year old 210 bed JCAH approved hospital. Send C.V. to Bill Rauwolf, SBLHC, P.O. Box 372, Mattoon 61938. 217-258-2577. (4)

MOUNT CARROLL:
G.P./Family Practice, solo practice. M.D. back up available, plus eleven EMTs on local ambulance crew. Small, historic, county seat community in unglaciated portion of northwest Illinois, ten miles east of Mississippi River. Great outdoor recreation, strong sense of community. Financial assistance available. Office space remodeled to suit. Excellent hospital facilities nearby. Contact: Laurie Scott, 302 N. Main., Mount Carroll, 61053. 815-244-1379;244-1407 (H). (5)

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SALEM:
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STREATOR:
Community of 22,000, serving population area of 70,000. Located 60 miles from Joliet and Peoria. Fully equipped hospital of 248 beds, with 41 physicians on staff. Cardiology, psychiatry and family practice specialities needed. Practice guarantees provided. Interested physicians are asked to send current resumes to: Terence Schuessler, Adm., St. Mary's Hospital, 111 Spring Street, Streator 61364. (4)

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FAMILY PRACTITIONER—Exceptional opportunity to acquire or begin a profitable practice in an extremely nice northwestern Illinois community. 92-Bed ITC nursing facility in town, hospital 12 miles away in Freeport, Ill. Hospital and community financial assistance offered: To inquire write Search Committee, P. O. Box 303, Lena, IL. 61048.

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OTOLARYNGOLOGIST—La Crosse, Wisconsin—Fifty-physician multispecialty group needs second general otolaryngologist to associate with busy, young, board-certified otolaryngologist. Modern 350-bed, full-service hospital adjacent to clinic, has well-equipped and staffed O.R., extensive X-ray coverage (including CT and ultrasound), and 24-hour E.R. staffing. First year guarantee plus incentive with generous benefits. City of 50,000 in beautiful Mississippi River valley with medical referral area of approximately 175,000. Exceptional cultural, educational and recreational opportunities locally. Contact P.S. Shultz, M.D., Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S. 10th St., La Crosse, WI 54601. Phone (608) 782-9760.

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INTERNIST—Third man wanted to join busy general internal medicine practice in Rock Island, Illinois. Private practice with guarantee of full partnership in one year. Office is located in modern 300 bed hospital. Please send resume to Greg Romans, c/o Franciscan Hospital, 2701 17th Street, Rock Island, IL 61201.

LA CROSSE, WI—Orthopedic Surgeon/Otolaryngologist needed to join 50-physician multispecialty group in city of 50,000 in beautiful Mississippi River Valley with patient drawing area of 175,000. Very busy two-physician Orthopedic Department. One young, board-certified otolaryngologist (only ENT specialist on hospital staff). Modern 350-bed, full-service hospital (adjacent to clinic) has well-equipped and staffed OR, comprehensive radiology (including CT scan/ultrasound), 24-hour E.R. staffing. Attractive compensation package (first year guarantee plus incentive) and generous fringe benefits. Contact P.S. Shultz, M.D., Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S. 10th St., La Crosse, WI 54601. Phone 608/782-9760.

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FAMILY PHYSICIAN WANTED—Prosperous community, outstanding recreational area. Town of 7000 population, 80 miles from downtown Chicago. Excellent position for partnership with older physician and opportunity to take over entire practice in near future. Write to Box 1116, c/o Illinois Medical Journal 55 E. Monroe St., Suite 3510 Chicago, IL 60603.

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PATHOLOGIST, AP/CP Certified, 10 years experience. U.S. graduate. University trained. Excellent training and references. Seeks challenging position. Reply to Box #1111, c/o *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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A Strategy That Works

Participatory Democracy



With the annual meeting of the House of Delegates recently completed, I am once again impressed with the democratic, representative manner in which Illinois State Medical Society policy is made. I wonder, however, if all our members feel as I do. I doubt it, because some of them have expressed to me their disappointment and displeasure that ISMS does not always agree with their personal views and philosophies. Therefore, I think it would be well to review just how the House discharges its constitutional responsibility of making ISMS policy.

I like to define policy as the stand the Society does or does not take on particular issues in which it *should* be involved.

Each and every ISMS member has the right of voice and vote in his county medical society (or Chicago Medical Society branch) to nominate and/or elect delegates to the ISMS House. There, resolutions, introduced by the delegates, often at the request of an individual member, are referred to a Reference Committee at which all members of the Society may testify. After considering the testimony given, the Reference Committee makes a recommendation to the House on each resolution. These recommendations and the resolution itself are then debated, under the rules of parliamentary procedure, and a vote is taken. The majority decides whether a resolution will pass or fail, thereby creating or modifying ISMS policy. The will of the majority is fundamental, as in all democratic organizations from the largest national to the smallest local group. For every majority, however, there is a minority. If the minority is dissatisfied with the opinion of the majority and still feels strongly, it must—and has a duty to—work at the county level to change the minds of the majority and thus the policy of ISMS.

Policy concerning the county and state will be implemented at the proper level. An issue of national significance will be taken to the floor of the House of Delegates of the American Medical Association by our Illinois Delegation; there it will be tested in exactly the same parliamentary manner and may or may not become *national* policy.

It is through this democratic and representative mechanism that *any* individual Society member can initiate the process whereby his or her idea can become Society policy. That member must, however, start the ball rolling.

You can't score if you're not playing the game. ◀

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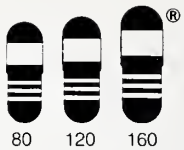


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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis; erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia; LE-like reactions; psoriasiform rashes; dry eyes; male impotence; and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

A SECOND OPINION

Simply Counting Doesn't Cut It

Staring at the Pickle Jar

In July, we introduced a correspondent whose missive gave us a refreshing perspective. Although Mr. Goodwins began to receive the Journal through a clerical error, he asked that we continue to send it. In exchange he has agreed to examine our work and correspond when appropriate. Comment and response via the IMJ offices are encouraged.

Dear Editor:

My recent medical reading would lead me to believe that quality of medical care is about as overdiscussed as the weather. To misquote another riverbottom lad, "Quality, like the weather, is something everyone talks about, but everyone has difficulty defining." Perhaps not everyone. It seems to me that doctors and politicians have the greatest difficulty. Strange to put those two distinguished groups of citizens into the same sentence but that's where I see the greatest confusion.

Tuesday morning, there was a lull in the usually snappy conversation at the 10:00 morning roundtable, and my gaze and thoughts wandered to the window on the street. Outside the window were two mothers with preschool kids staring at the pickle jar full of jellybeans that Lefty had set there to stimulate business. I am sure all of your readers will recognize the "count the number of jellybeans in the jar" promotion. The prize for the correct answer was a Sunday chicken dinner for two. So far the jar of jellybeans hadn't drawn a lot of paying customers—perhaps the value and appeal of winning such a prize was less than anticipated. The interest among the small fry, however, was great; and these two mothers were being held in place by three younguns who could be heard through the window debating not the numbers of beans but the relative desirability of black jelly beans over red jellybeans—truly an issue of quality.

The quantity of the beans will ultimately be determined and some poor soul will come face to face with deep fried chicken, mashed potatoes, brown gravy and corn on the cobb one Sunday afternoon yet to be determined. An easy task all around.

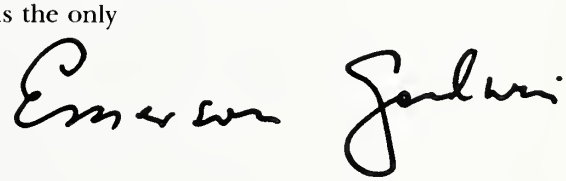
On the issue of quality, however, simply counting doesn't cut it. Quality is judgmental and, as with judgmental things, it depends on the judgment of the beholder. Young Chester outside the window saw the black beans as those of quality while Missy had her quality judgment already decided in favor of the red beans.

I suspect it's much that way with medical care. The beholder, *i.e.,* the patient, judges the quality in terms that he or she can understand—how long do I have to wait, is the waiting room nicely appointed, are the examining rooms clean, are the staff friendly and is the doctor a nice guy. That patient really can't judge the quality of the actual care received. Another physician can judge that and probably is the only one truly capable of determining the actual quality of the care. Perhaps that's where and why you folk developed your peer review concept. And I expect that nurses or hospital administrators or office staffs all have their individual views of what constitutes quality.

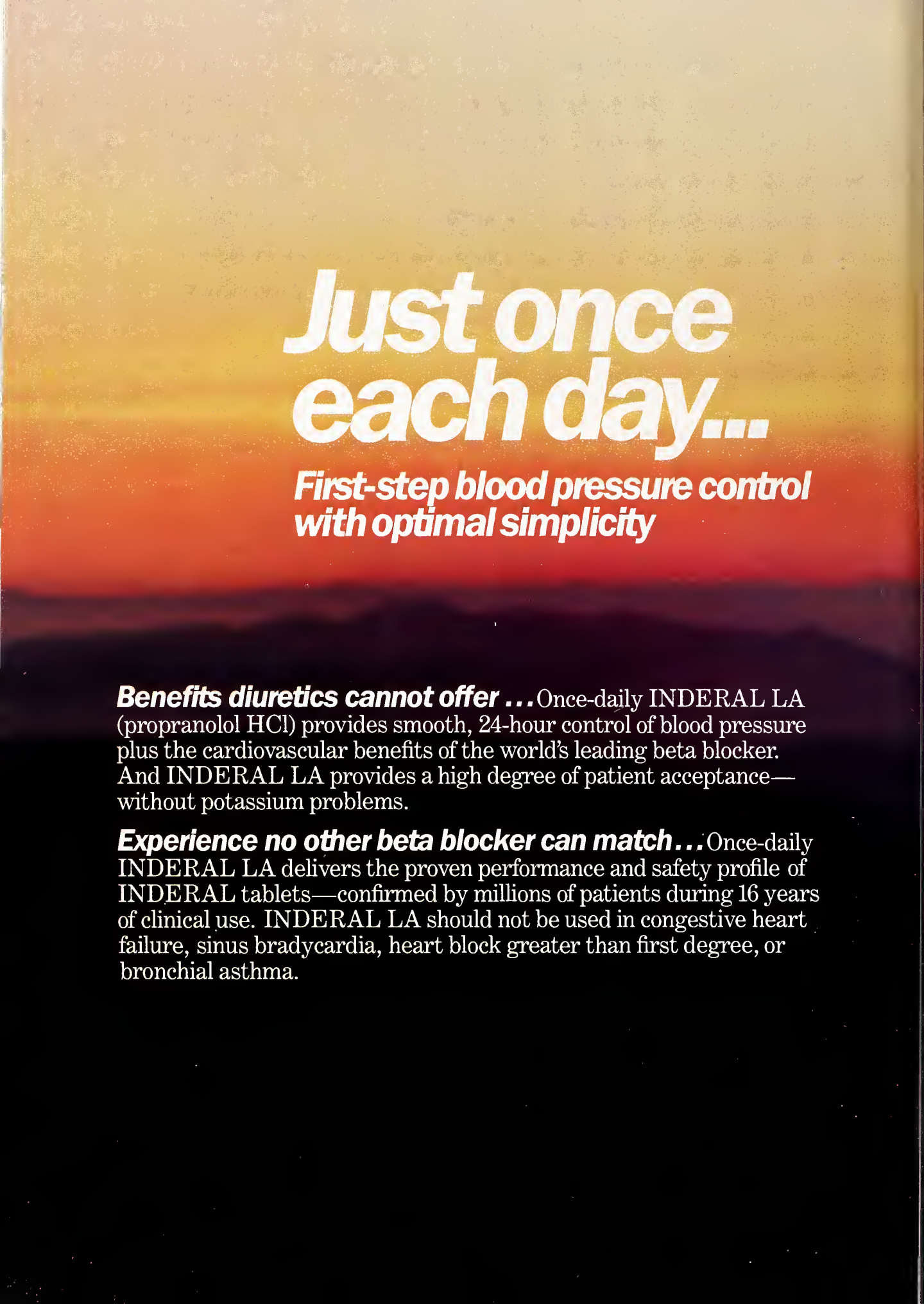
It seems to me that that's the hallmark of quality—the judgment of the person for whom that service is being performed. And medical care is a service—not a product and therefore not very comparable on a case-by-case or item-by-item basis. Purely judgmental, fairly subjective, and quite individual.

Now I know why quality is so hard to define. But I am still not sure why the definition of quality should be such a big issue to society, physicians, and/or politicians. All of the learned minds in the professions and some in the State House may never be able to come up with an adequate, acceptable-to-all definition—anymore than Chester and Missy will be able to agree on the issue of red versus black jellybeans.

Certainly it's easier to count those beans. ◂



Sincerely,
Emerson Goodwins


Just once each day...
First-step blood pressure control with optimal simplicity
Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.
Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Just once each day for initial therapy in hypertension.

Ayerst®

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

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INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

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PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

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Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

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Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

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If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

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PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., ASSOCIATE PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was prepared by Mary C. Olson, M.D., department of radiology, Loyola University Medical Center, Maywood.

An 11 year old previously healthy boy developed a productive cough and fever. A PA chest radiograph (Figure 1A) showed bilateral infiltrates and a right upper lobe mass. Symptoms rapidly cleared following the initiation of cephalexin therapy. Six weeks later he was asymptomatic but the RUL mass was unchanged (Figure 1B).



Figure 1A.
There is bilateral perihilar lung consolidation plus an RUL mass.

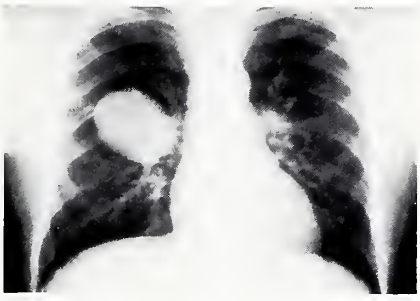


Figure 1B.
Six weeks later the lung consolidation has cleared but the RUL mass is unchanged.

Your diagnosis?

(a) Hamartoma
(b) Plasma cell granuloma
(c) Round pneumonia
(d) Metastatic neuroblastoma

(Continued on page 356)

DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Officers recently elected to the Sangamon County Medical Society are: **Michael Snyder, M.D.,** president; **Norman Scheibling, M.D.,** president-elect; and **Elvin Zook, M.D.,** secretary-treasurer, all of Springfield.

ISMS past president **J.M. Ingalls, M.D.,** Paris, has been appointed to a three year term as a trustee of the Illinois Hospital Association. IHA officials have pointed out that Dr. Ingalls is the first physician in active practice invited to serve on the Board.

MEDICAL APPLIANCES SALES TAX

Sales of medical appliances used by health care professionals in providing medical services do not qualify for the reduced tax rate afforded drug and medical appliances by the Department of Revenue, according to an Illinois Pharmacists Association newsletter. Pharmacists who sell medical appliances to physicians for office use are responsible for payment of the full tax rate.

FREE REGISTRATION FOR PHYSICIANS' PLACEMENT SERVICE

Physicians' placement service, a computerized information clearinghouse that provides listings of practice opportunities in most medical specialities, is offering free registration to members, according to the *AMA Newsletter.* Two bi-monthly registers published by PPS are the "Opportunity Placement Register," which contains brief descriptions of available practice opportunities, and the "Physician Placement Register," which contains abbreviated curricula vitae. Further information may be obtained by contacting Joe Ann Jackson, (312) 645-4712.

ENGLISH SEMINARS FOR FOREIGN-BORN PHYSICIANS

The AMA is sponsoring one day seminars to help foreign-born physicians improve their English pronunciation. The next local workshop will be held June 2 at the Chicago Marriott, Chicago. Further information may be obtained by contacting G.K. Jewett, Department of Physician Qualifications, AMA headquarters, 535 N. Dearborn St., Chicago, IL 60610 or phone (312) 645-4676.

SIU LECTURESHIP

The Southern Illinois University School of Medicine, Springfield, has established the first lectureship for the school's department of internal medicine in honor of Cecil L. Martin, M.D., Belleville. Dr. Martin, who died last August, served over 50 years as a physician in Belleville. The Dr. Cecil L. Martin Distinguished Lectureship in Internal Medicine is funded by the memorials honoring the physician and a substantial gift from his family.

Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety, for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

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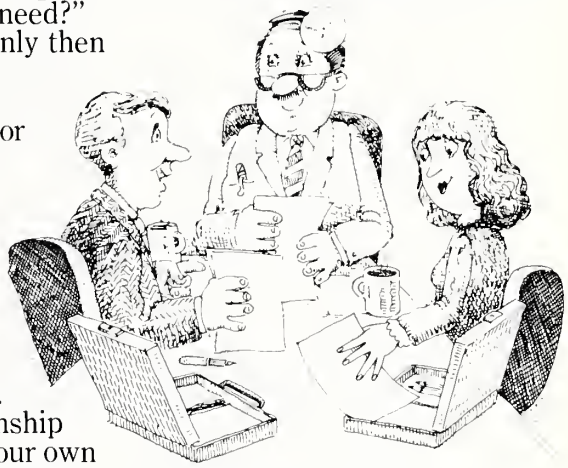
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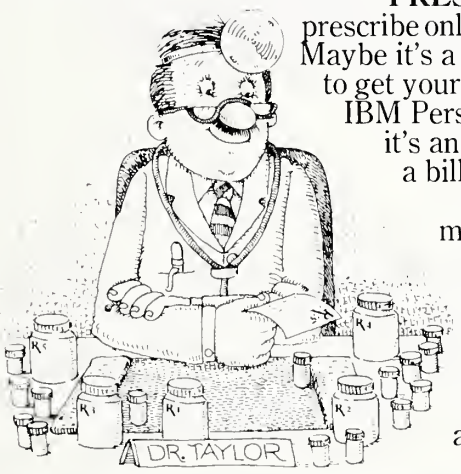
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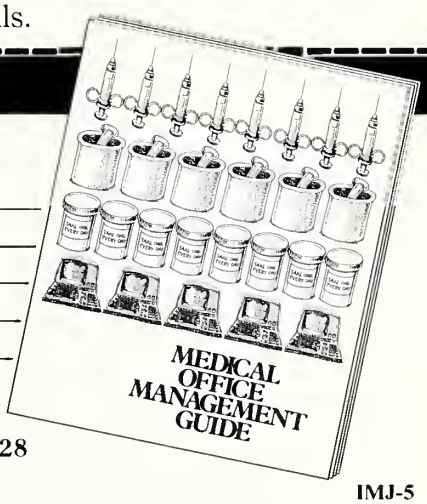
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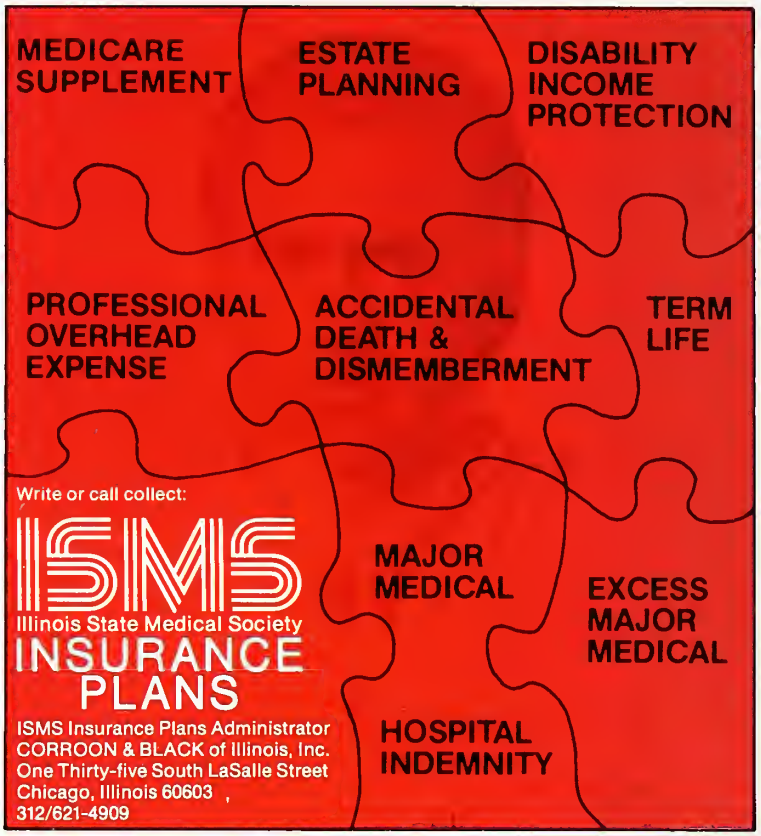
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Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

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A Few More Sentences On Prison Health Care

To The Editor:

As Medical Director of the Illinois Department of Corrections, I read with interest the article by Dr. Beguelin, who is currently the Project Director of the Vandalia Correctional Center's contractual medical group. (Ed. Note: "A Systematic Approach to Prison Health Care," by Jerry L. Beguelin, M.D., 164: 5, 411-416, November 1983) Although much of what was written in the article may prove to be both useful and instructive, I feel that there are aspects of it which may distort the public perception and need further elucidation.

First of all, Dr. Beguelin has not been the Medical Director at the Pontiac Correctional Center for the last four years. He currently is affiliated with a medium security institution in South Central Illinois. Many of the problems which he describes relate to conditions that were found in law suits that were generated in the early and middle 70's. Many of those conditions have been eliminated or dramatically altered. Before taking my current job with the Illinois Department of Corrections, I spent seven years as a consultant to the Justice Department looking into allegations of inadequate medical care in institutions around the country. As a result of that experience, I can say unequivocally that both the medical care and in fact, the living conditions in general in the Illinois Department of Corrections, are superior to those found in most other states. I would like to address just a few of the issues that Dr. Beguelin discussed in his article.

One of the first problems he discussed was inmate access to medical services. I can say unequivocally that in all of the Illinois prison facilities, inmates have direct access to health care staff on a daily basis. They do not have to utilize officers as intermediaries. This is even true of inmates who are confined to their cells for disciplinary reasons.

Secondly, we have licensed professional staff in all our Adult Correctional institutions around the clock and, in fact, in two of our maximum security institutions we have physicians on site 24-hours-a-day, 7-days-a-week. Therefore, the issue of access to licensed or properly trained personnel is not currently a problem in the Illinois Department of Corrections. Although a minority of inmates may attempt to see the physician for other than medical reasons, our providers will state that the vast majority of inmates come to sick call or request physician attention as a result of their perception of either medical or emotional problems.

Although one can always criticize public sector institution staffing patterns in comparison to private sector institutions, the fact is that the State of Illinois within the past five years has increased the resources for the provision of medical services such that we are now able to both adequately staff our prisons and provide physicians with appropriate salary arrangements.

Another point necessarily mentioned is the fact that the security administration; *i.e.*, the wardens at our institutions, are almost without exception professionals. They understand the needs and requirements of providing proper services. In Illinois the time is long past when a warden or assistant warden would interfere with the necessary treatment of an inmate. In fact, any time an inmate needs to receive treatment outside of the institution arrangements are made for that treatment to be obtained. With regard to medical records, all of our facilities now utilize a standard problem oriented format for the medical records and any time an

individual is transferred from one facility to another his record is transported with him. With the completion of the renovation of the medical unit at Pontiac within the next month, all of our maximum security institutions with the exception of Stateville will have renovated medical units. The Stateville medical unit is, in fact, part of a Capital Development Board project to be initiated in the near future.

In summary, what I would like to indicate is that Dr. Beguelin's article, although instructive, is in many ways quite dated. Currently the working conditions in the Illinois Department of Corrections' institutions are quite up to professional standards, both with regard to physical plant, equipment and in particular with regard to staffing. We have been able through contracting and other means to provide the necessary salary arrangements which enable us to compete effectively with the free world. As the prison population expands, we are in the process of adding new institutions. All of the institutions in the planning stages are either minimum or medium security. We will be looking for more physicians to join our team. I am absolutely certain that interested physicians could find practicing in our prison environments a rewarding experience both financially as well as professionally.

Sincerely,
Ronald M. Shansky, M.D.
Chicago

The Author Responds

I have reviewed the letter submitted by Dr. Shansky and I have to agree the historical information is dated, inasmuch as the article was first submitted for publication on 15 March 1979. I have worked with Dr. Shansky professionally since he has been the Medical Director of the Department of Corrections and have found him uncompromising in expecting inmates to receive quality medical care. I think that the thrust of my article has been misconstrued. My description of the historical problems in prisons was used to illustrate the circumstances that existed prior to *Cook vs. Roe.* My emphasis is on 'systems' as stated in the title, "A Systematic Approach to Prison Health Care" and as was stated in my letter to the *IMJ* when I submitted the article.

Physicians have been frequently accused of being a "cottage industry" and this article was an example of one way to approach medical services in a unique environment. I think it is essential that physicians lead in the development of systems to respond to special circumstances in our environment. Just as during the 70's there were upheavals in the way medical services were delivered in prisons, there are currently occurring upheavals in the way services are going to be funded and delivered under Medicare and DRG's. Medical services in prisons were underfunded because of "cost constraints" and administrators (wardens) were deciding which services were 'medically necessary.' Today we are faced with administrators (PRO's) deciding which services are 'medically necessary' (admission criteria). These circumstances may rapidly lead to lawsuits similar to those brought by prisoners.

Dr. Hiatt, dean of Harvard University's School of Public Health and professor of medicine at Harvard Medical School, in an article in the *Harvard Business Review,* January-February 1984, on Health Care in America, wrote: "What has emerged is a system, or a series of unrelated systems, marvelous in technical capabilities and achievements, yet fragmented and inefficient . . . everyone who has an interest in American medicine . . . must agree that we cannot afford to maintain the status quo."

I think it is as important for the *IMJ* to report on innovative organized systems approaches to medical care as it is to describe new surgical or drug modalities. I see the publication of my article as an acceptance by the *IMJ* that the development of systems of delivery of medical care is an important science.

Sincerely yours,
Jerry L. Beguelin, M.D.
Irvington

Obituaries

***Beers, Morrison D.,** Lake Forest, died March 24, 1984 at the age of 69. Dr. Beers was a 1942 graduate of Northwestern University Medical School, Chicago.

****Cohen, Bernard,** Tucson, Arizona, died March 18, 1984 at the age of 75. Dr. Cohen was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

****Cravens, Harvey G.,** Quincy, died February 21, 1984 at the age of 86. Dr. Cravens was a 1923 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

***De Pree, Earl,** Chicago, died March 13, 1984 at the age of 75. Dr. De Pree was a 1936 graduate of Rush Medical College, Chicago.

***Hora, James L.,** Western Springs, died March 28, 1984 at the age of 72. Dr. Hora was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

***Mandernack, Loren E.,** Flossmoor, died March 17, 1984 at the age of 72. Dr. Mandernack was a 1941 graduate of Loyola University Stritch School of Medicine, Maywood.

****Montezon, A. F.,** Eagle River, died March 13, 1984 at the age of 88. Dr. Montezon was a 1925 graduate of the University of Illinois College of Medicine, Chicago.

****Phillips, Hans,** Kewanee, died November 28, 1984 at the age of 57. Dr. Phillips was a 1952 graduate of *Medizinsche Fakultat de Universitat Graz,* Graz, Austria.

****Raymond, Sidney W.,** Chicago, died March 11, 1984 at the age of 83. Dr. Raymond was a 1927 graduate of the University of Illinois College of Medicine, Chicago.

***Robinson, A.L.,** Mounds, died March 6, 1984 at the age of 75. Dr. Robinson was a 1936 graduate of Howard University College of Medicine, Washington, D.C.

****Schacht, Frederick W.,** Evanston, died March 27, 1984 at the age of 86. Dr. Schacht was a 1926 graduate of Johns Hopkins University School of Medicine, Baltimore.

****Weishaar, Herman O.,** Evanston, died March 4, 1984 at the age of 94. Dr. Weishaar was a 1918 graduate of Rush Medical College, Chicago.

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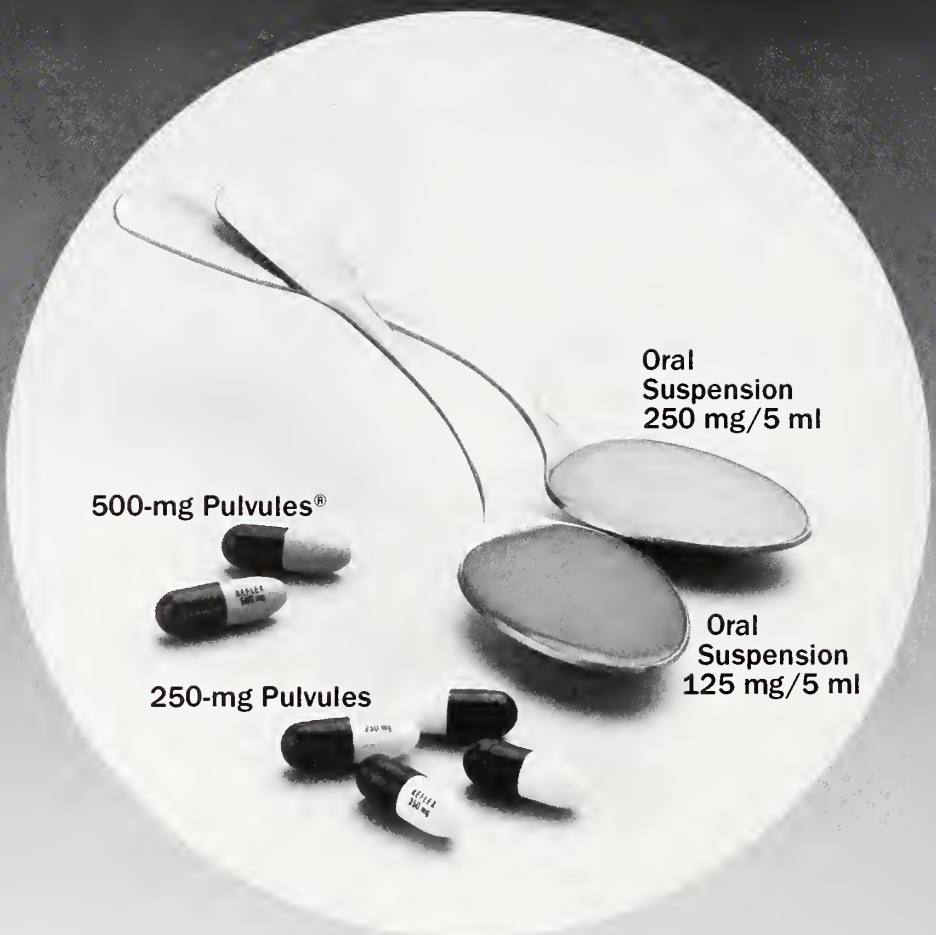
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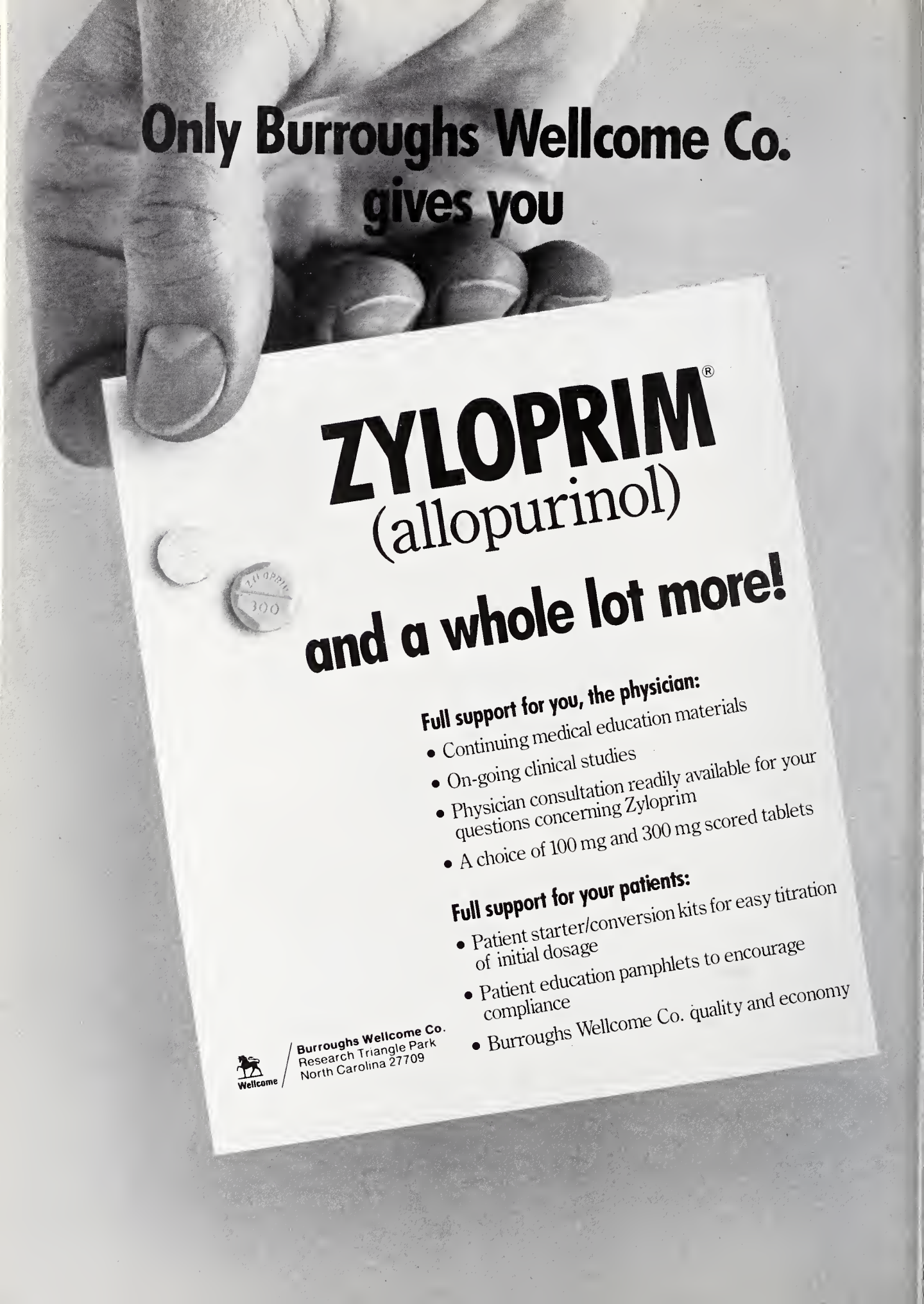
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(Continued on page 341)

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Additional NMR information on page 353

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Mirror Image Arteriovenous Malformations of the Brain

By Mohammed Naseem, M.D., Orestes Sanchez, M.D., and Ata O. Rezvanpour, M.D./Chicago

A single case of bilateral parietal mirror image arteriovenous malformations (AVMs) is presented. This represents a new variation of the multifocal intracranial AVMs previously described in the literature. CT was initially performed but only with diagnosis of the intracerebral and intraventricular hemorrhage. Full four vessel cerebral angiography was necessary for the demonstration of the arteriovenous malformations. Four vessel cerebral angiography is still necessary for the diagnosis of AVMs and for pre-surgical vascular mapping of the lesion.

Since the description of the first AVM by Luschka in 1854 and the development of cerebral angiography by Monis in 1929, there have been few reports of multifocal AVMs. Schlecter[1] described four cases as unilateral intracerebral, bilateral deep midline, intracerebral with a tentorial lesion and bilateral intracerebral. The bilateral AVMs were only demonstrated post-operatively, prior to complete angiography. The question remains whether they were initially single large bilateral lesions. Perret and Nishioka[2] described three cases but did not elaborate. Finally, Boldrey,[3] in an unpublished series of 270 angiomatous malformations, discovered multiple lesions in 13 cases at angiography and five more at autopsy. We present a case in which the initial CT scan did not demonstrate the bilateral AVMs but rather a large intracerebral hematoma with ventricular communication. Subsequent four vessel cerebral angiography demonstrated the lesions that were resected surgically.

Case Report

B.B. is a 20 year old white male who was transferred to our facility from an outlying hospital in status epilepticus. Physical examination revealed an obtunded mental status with enlarging right pupil and bilateral decerebrate posturing. CT scan (performed at another hospital) showed a large left temporoparietal intracerebral hematoma with communication to the left lateral ventricle (Fig. 1). The patient underwent emergency decompressive craniotomy and a large blood clot was evacuated. Postsurgically the patient was initially comatose and agitated but gradually began to improve.

He underwent four vessel cerebral angiography, while recovering from the operation. The study demonstrated bilateral mirror image AVMs in the temporo-parietal

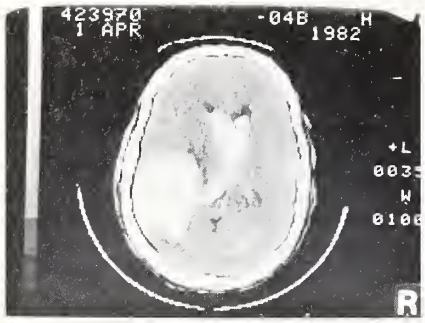


Figure 1
Initial unenhanced CT. Notice the massive left temporoparietal intracerebral hematoma with ventricular communication. There is moderate mass effect. The right hemisphere is otherwise normal.

region measuring 2cm.×1cm. on the right and 2cm.×1.5cm. on the left. The blood supply of these lesions originated from the angular branch of the middle cerebral artery (MCA), on each side (Fig. 2).

The patient underwent (one month later) left craniotomy for the removal of a large AVM encompassing the arterialized vein of Labbe, feeding vessels from the angular artery and large tortuous vessels at the base of the malformation. Recovery was satisfactory and the patient was scheduled for a right craniotomy in one month.

Repeat selective four vessel cerebral angiography demonstrated absence of the left AVM with post-surgical changes and a small 2cm.×1cm. right AVM (Fig. 3).

The patient underwent right temporo-parietal craniotomy with excision of a 2cm.×1cm. AVM in the supramarginal gyrus with feeding vessels from the angular branch of the MCA. The patient tolerated the procedure well with progressive resolution of Wernicke's aphasia and poor comprehension. Repeat selective cerebral angiography showed complete resolution of both AVMs (Fig. 4).

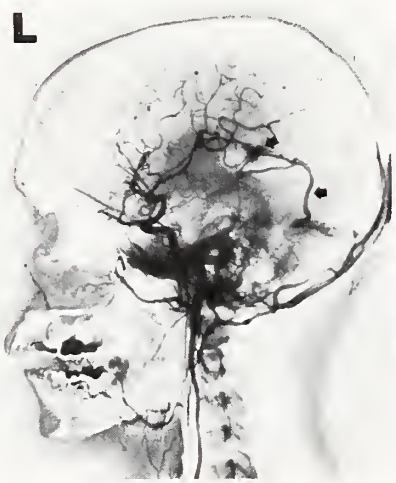
Discussion

AVMs are congenital lesions characterized by a collection of arterialized veins having an abnormal or absent capillary bed.[4] AVMs have the capability of changing both structurally and hemodynamically. They may present with a myriad of neurological problems, *e.g.*, seizures (50%), intracerebral or subarachnoid hemorrhage (40%), transient or progressive headache (38%), motor deficit (37%), visual defects (28%), mental deficit (28%), and sensory deficit (15%).[5] The presentation has a direct bearing on the eventual diagnosis with the location correlating well with surgical correction and eventual prognosis.[6]

AVMs have previously been described as single entities with either unique or multiple blood supplies. The most common tributary is the MCA (53%) followed by the posterior cerebral and anterior cerebral arteries in equal frequency, the basilar artery and one instance of persistent trigeminal artery. The distribution is predominantly supratentorial with only a handful in the posterior fossa. There is a 2:1 male to female ratio in supratentorial lesions with equal distribution for infratentorial lesions. The vascular supply of the AVM does not correlate with sex, size of lesion or laterality.[4,5,7]

Cerebral angiogram selective left common carotid injection AP, lateral. Notice a single AVM originating from the angular branch of the MCA having a large draining vein that feeds into the transverse sinus on the left. There is no crossover of the intracerebral branches of either the MCA or ACA noted.





Figures 2 a, b (left and above)



Figure 2c
Right common carotid injection; lateral projection. There is an AVM in the distribution of the angular branch of the MCA that has a large draining vein of Labbe. Note the craniotomy on the left from the initial decompression and the pressure monitoring screw.



Figure 3a
Left common carotid injection, lateral view. The left AVM has been completely resected. There is a normal appearing angular branch of the MCA with no abnormal vessels



Figure 3b
Right common carotid injection, lateral view. The right AVM is again visualized.

In the case presented, one can see on angiography the separate unique blood supplies of the AVMs. Their blood supply is the angular branch of the MCA with a large draining vein of Labbe. At no time on the serial films is there seen crossover of the intracerebral circulation to suggest a common origin. A post-operative angiogram evidenced complete surgical removal of the bilateral AVMs.

The CT scan was used to initially evaluate the patient and proved efficient in diagnosing the intracerebral hematoma but failed to pick up the right AVM. This failure to demonstrate the AVMs may be related to the fact that only an unenhanced scan was performed and to the use of an early generation scanner.[8]

In conclusion, multiple modalities have been utilized through the years for the diagnosis of AVMs, from the early described skull X-ray changes to air ventriculography, dynamic radionuclide angiography, selective cerebral angiography, and most recently computerized axial tomography.[7] With only a few exceptions[9] cerebral angiography remains the "gold standard" for the diagnosis of AVMs because we can use it to confirm the diagnosis, localize the lesion exactly, map the feeding arteries and draining veins, and evaluate the feasibility of non-surgical management by embolization.[1] Computed tomography is a sophisticated, non-invasive imaging modality with a diagnostic accuracy of 23% on unenhanced scan and 90% on enhanced scan. With the improvements in resolution and scanning techniques such as dynamic scanning available on the newer machines, the diagnostic accuracy should improve beyond 90% in the near future.[7-9]

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Figure 4
Right common carotid injection. Postoperatively, the right AVM has been completely resected with no residual abnormal vascularity.

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Diagnosis and Management

Pulmonary Embolism During Stroke Rehabilitation

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Hines and Wheaton

This paper was first presented before the American Congress/Academy of Physical Medicine and Rehabilitation, Houston, Texas, November 2, 1982.

Stroke patients are considered to be at high risk for venous thromboembolic phenomena. Prophylactic anticoagulation is not yet an acceptable management. Charts of 363 stroke patients admitted to a free standing rehabilitation hospital from January to December, 1980 were reviewed. Fifteen of these patients (4%) developed pulmonary emboli, 20% had thrombophlebitis, and one patient had a history of pulmonary embolism. Common symptoms were chest pain (53%), fever (46%), and dyspnea (40%). Average rehabilitation stay prior to symptoms was 11 days, with 53% less than seven days and 46% more than 27 days. Twenty-six percent were ambulatory when symptoms occurred. Delay in diagnosis occurred when low-grade fever was the only presenting symptom. Four patients had recent G.I. bleeding; 46% had associated hypertension. Repeat chest X-ray and EKG were helpful only in excluding other diagnoses. Lung scan was done in 14 patients, and positive in all of these. All but one of these patients were transferred to an acute care hospital. Two died and 66% of the remaining 12 patients were readmitted. In this retrospective study, it was felt that prophylactic anticoagulation still could not be justified in the majority of cases.

Background

True incidence of pulmonary embolism (PE) in stroke patients is difficult to assess; there are very few reports available in the literature regarding this problem. Mortality from PE in hospitalized patients ranges from 18% to 38%. In contrast, the mortality of treated PE was only 8% in the multicenter trial of thrombolytic agents sponsored by the National Heart and Lung Institute.[1] Miyamoto, *et. al.*[2] reported 9% incidence of PE and 1.5% incidence of thrombophlebitis in a group of 68 stroke patients. Kucera[3] found PE at autopsy in 37% of patients dying from apoplexy. In 10%, it was the main cause of death. Warlow[4] quoted 16% as the "over-all frequency" of PE, but stated that it was notoriously difficult to determine, particularly in the elderly, unconscious, or aphasic patients. Warlow,[5] in another study of 76 stroke patients, found 9% definite, 7% probable incidence of PE in stroke patients. Warlow[4] analyzed incidence and predisposing factors of deep vein thrombosis (DVT) of the legs after stroke in 76 patients; he found 53% DVT in the paralyzed leg and only 7% in the non-paralyzed extremity. He questioned the role of bed rest, as the findings suggested that the paralyzed lower extremity had a higher risk of DVT than the normal, opposite, lower extremity or paralyzed upper extremity. The duration of bed rest was also not related to the frequency of DVT occurrence. It was estimated that approximately 50% of DVTs in the iliofemoral venous system embolize,[6] although which patients would experience embolism and which would not are not known.

Physical measures, including leg elevation, range of movement exercises, support stockings, early ambulation and intermittent pneumatic compression have not been conclusively proven to prevent DVT. Virchow's postulations about precipitating factors for thrombosis: (1) changes in the blood flow pattern (stasis); (2) changes in the

blood promoting hypercoagulability and (3) changes in the blood vessel walls, have to be given serious consideration in treatment or preventive measures. DVT was reported to occur either during prolonged surgical procedures or within 48 hours after the operation; PE was seen 8-14 days after surgery.[6] Whether the same time frame can be used for stroke patients is questionable. Lack of such information means that any management plan is essentially empirical. Even if treatment is to be given, its initiation and termination are difficult decisions in stroke patients, as recovery from the original condition is most often incomplete.

Table 1
Presenting Symptoms* and Investigations

Symptom	Patients	Percentage
Chest pain	8	53%
Dyspnea	6	40%
Hemoptysis	1	6%
Fever	7	46%
Systemic hypotension	2	13%
Transient neurologic symptoms	1	6%
Chest roentgenogram	10	67%
Electrocardiogram	6	40%
Lung scan (V/P)	14	93%
Arterial blood gases	2	13%

**Most patients had more than one presenting symptom*

Materials and Methods

Records of 363 patients admitted with a diagnosis of stroke to a free-standing rehabilitation center during calendar year 1980 were reviewed. Of these patients, 15 (4.1%) were noted to have developed PE during the rehabilitation process. These patients' charts were critically analyzed for age, sex, associated conditions that predisposed for PE, and contraindications to anticoagulation. Length of stay in acute care hospitals prior to transfer to rehabilitation, duration of stay in the rehabilitation program before diagnosis of PE, and transfer back to acute care hospitals were noted. Presenting symptoms and time interval between diagnosis and transfer to acute care were analyzed. Mortality rates, final discharge status after completion of rehabilitation, and complications of management were noted.

Results

Age and sex: The ages of these 15 patients ranged from 47 to 84 years. The median age was 70.5 years. There were five patients (33%) below 60 years of age. There were eight females and seven males in this study.

Side involved: There were six right hemiplegics with aphasia and nine left hemiplegics.

Length of stay: Patients were transferred to rehabilitation from acute care hospitals after an average stay of 27 days, with a range from 14 to 75 days. Diagnosis of PE and transfers to acute care hospitals for management occurred after an average stay of 11 days in the rehabilitation program, ranging from one to 50 days. Five patients stayed less than seven days; seven stayed longer than 21 days. Of those who stayed longer than 21 days, 57% were ambulatory.

Symptoms and signs: Patients often presented with more than one symptom. In the six aphasic patients, accurate assessment of symptoms was difficult. The most common symptoms noted were chest pain (53%), fever (46%), and dyspnea (40%) (Table 1). Some other associated observations were systemic hypotension (13%), hemoptysis (6%), and transient neurologic signs (6%). A diagnosis of PE was made after an average interval of two days from onset of symptoms; it ranged from 0-7 days. A delay in definite diagnosis occurred when the initial presenting symptom was fever.

Associated conditions: As shown in Table 2, stroke was caused by intracerebral hemorrhage in four of fifteen patients. One had upper G.I. bleeding during the acute stage of stroke management and was treated conservatively and seven had a history of hypertension. A diagnosis of thrombophlebitis was made in two patients and suspected in one other patient because of unilateral edema, accounting for 20% occurrence of DVT in this study group of 15 patients. One patient had a history of previous PE but was not on any anticoagulants when symptoms occurred. One patient developed cardiopulmonary arrest and was resuscitated prior to transfer to an acute care hospital.

Investigations: After onset of symptoms, ten patients had repeat chest X-rays and six patients had repeat ECGs; blood gases were done in two. None of these tests yielded any conclusive evidence leading to a diagnosis of PE. The majority of these tests were done to investigate chest pain or fever, and at that stage PE was not clinically suspected. Fourteen patients (93.3%) had a ventilation/perfusion (V/P) lung scan done. All 14 patients were reported to have perfusion defects and were suspected of having PE.

Other observations: Six patients were taking dipyridamole when symptoms developed. This medication was prescribed to decrease platelet aggregation and prevent thrombosis and embolization in the arterial system. One patient developed PE while being treated with subcutaneous heparin for DVT.

Outcome of management: Eight of the 14 patients (53%) transferred to acute care hospitals were readmitted to rehabilitation and the pro-

gram was completed without further complications. One patient was treated with anticoagulants and the rehabilitation program was continued successfully without transfer to an acute care hospital. Seven of nine patients (77%) went home after readmission into the rehabilitation program. Two of nine patients (22%) were transferred to extended care facilities at an increased level of independence. Four other patients (26%) were dismissed directly from acute care hospitals and further details were not available. Two of 14 patients (14%) expired after transfer to acute care facilities for treatment.

Table 2
Associated conditions

Symptom	Patients	Percentage
Hypertension	7	46%
Intracerebral Hemorrhage	4	26%
Recent upper G.I. bleed	1	6%
Thrombophlebitis	2	20%
Unilateral edema	1	
History of pulmonary embolus	1	6%

Discussion

Age and sex: Rosenow[6] stated that patients more than 60 years old had an increased incidence of DVT. In most studies, the average age of stroke patients had been more than 60 years.

Time of occurrence of PE in stroke patients: The majority of published reports mentioned PE during stroke rehabilitation as part of the main study, either for identification of DVT[3,4,7] or prophylaxis for prevention of DVT and PE.[7] Most studies reported observations at autopsy or during the acute phase of stroke management.[3,4,7] Miyamoto[2] studied 141 stroke patients after transfer to a rehabilitation unit, 10-14 days after onset of the patient's acute insult. McCarthy[7] showed by I-125 fibrinogen study that DVT occurred during the first 14 days after a stroke, with the peak incidence about the fifth day. Warlow,[8] in a study of 13 stroke patients, found the maximum incidence of DVT within the first few days. None of these studies mentioned when the PE occurred. Rosenow,[6] in a review article, reported that the average interval between surgery and PE was eight to 12 days; whether the same time frame could be extrapolated for stroke patients is questionable.

In our study group, the median stay in the acute care hospital prior to transfer to our rehabilitation facility was 27 days. Symptoms suggestive of PE occurred after a median stay of 11 days in the program; five patients (33%) stayed less than seven days and seven patients (47%) stayed longer than 21 days. Of the seven patients, 57% were ambulatory when symptoms occurred. The possibility of stroke patients, transferred to rehabilitation hospitals, embolizing from already existing clinically silent DVT cannot be ruled out. At the same time, mobilization after prolonged rest cannot be confirmed as a factor initiating the embolization because of the widespread variable intervals during which PE occurred from the time of the stroke.

Diagnosis: Symptoms observed in the study group and their frequencies were in agreement with other studies.[1,5] Systemic hypotension was noted in 13% and one patient developed transient neurologic symptoms. We were surprised to note that seven (46%) had only fever as a symptom. Delay in diagnosis commonly occurred when fever was the main presenting symptom, as the patient was investigated for other common causes such as urinary tract infection from neurogenic bladder or pulmonary atelectasis before PE was considered. One patient developed cardiopulmonary arrest while being investigated.

Rosenow[6] stated that, "the chest roentgenogram is not quite as nonspecific as the electrocardiogram but is almost so." It was interesting to note that after the diagnosis of PE had been established, subtle abnormalities could be seen on the "normal" chest roentgenograms in retrospect. The majority of emboli are said to occur in the right lower lobe. Parenchymal infiltration was found in 10% to 50%, infarction in 10%, and nearly one third of the patients may have had transient pleural effusion. Sasahara[1] concluded that in patients with cardiopulmonary distress, a consolidation or high diaphragm should make the clinician aware of the possibility of PE/infarction. An electrocardiogram (ECG) was repeated in six patients (40%) but once again, was only helpful in excluding evidence of myocardial ischemia as the cause of chest pain. Rosenow[6] stated that ECG was abnormal in up to 85% of patients with acute PE, but these changes were notoriously transient and very nonspecific. Sasahara[1] tabulated common ECG changes and also felt it was helpful in excluding MI; otherwise it was nonspecific. A lung scan (V/P) was performed in 14 of 15 patients (93.3%) and reported as "positive" in all cases. In addition to the clinical picture, the lung scan was used as the mainstay in confirming the diagnosis of PE. Some authors[6,7] observed that normal lung scan is quite specific in ruling out the diagnosis of PE; however, an abnormal V/P lung scan was not synonymous with acute PE. None of the patients in this study had pulmonary angiography for confirmation of PE. Similarly, none of these 15 patients nor the other stroke patients (totaling 363) admitted had I-125 fibrinogen study, plethysmography, venous doppler examination, radionuclide venography or venography to identify the

existence of DVT. Two of the 15 patients had clinical evidence of thrombophlebitis and another patient was suspected of having DVT because of unilateral edema; a total of 20% (three of 15). The frequency of a clinical diagnosis of DVT in patients that developed PE was variable. Miyamoto[2] found 1.5% incidence of DVT and 9% incidence of PE in a group of 68 patients, whereas a 29% incidence of DVT was found in 141 patients using I-125 fibrinogen leg scans. McCarthy[7] and Warlow[4] reported 75% and 53% incidence rates of DVT using the same technique. Miyamoto[2] related low positive test rates to the diminishing prevalence of thrombus formation with the passage of time after the acute stroke, possibly due to systemic factors or improved mobilization of the paretic limbs. Sasahara[1] reported a high degree of correlation in the relationship between PE and deep vein obstruction. In those patients with angiographically proven PE, the impedence plethysmography (IPG) was abnormal in 95%.

Analysis of arterial blood gases can be helpful, especially in the exclusion of PE. If arterial oxygen tension results are 90mmHg or greater, the likelihood of PE is remote, and if lung scanning is not readily available, the diagnostic evaluation for PE may end there.[6] On the other hand, for obvious reasons, PaO_2 of less than 80torr was not diagnostic of PE.[5]

Management

Prophylaxis: None of the patients in this series were anticoagulated prophylactically to prevent DVT and PE. It was noted that six patients (40%) were on dipyridamole as an antiplatelet agent for prevention of thrombosis and emboli in the arterial system. The dosage used was variable from patient to patient. Lazerson[9] stated that "the antiplatelet aggregating effect occurs only at dosages on the order of 400mg per day," which is much higher than that normally used. Salzman[10] reported that studies failed to show a significant protective effect with this agent. He reviewed the role of various other antiplatelet agents in thromboembolism. Physical methods of prophylaxis against DVT are all based on the principle of the prevention of venous stasis and facilitation or substitution for the action of the calf muscles. Fortunately, all these measures are non-invasive and do not carry any known risk. Collins[11] analytically reviewed the efficacies of these measures and their effect on venous hemodynamics. Although all these procedures facilitate venous circulation experimentally, there is limited clinical evidence that leg elevation, proper elastic stockings, external pneumatic compression, or electrical muscle stimulation prevent DVT. Enough clinical experience with postsurgical patients has shown that early range of movement (ROM) exercises and early ambulation decrease the chances of DVT and embolization.

Role of prophylactic anticoagulation: Unlike the hip, knee, abdominal, and thoracic surgeries, as well as post-myocardial infarctions,[12] there are very few reports of prophylactic anticoagulation (A/C) in stroke patients. McCarthy found in a study of 16 heparin-treated patients and 16 control group patients that only 12.5% of the treated group had positive leg scan studies, while 75% of the control group had positive leg scan studies.[7] The patients were treated with 5,000 units of calcium heparin subcutaneously for 14 days. Miyamoto[2] studied 141 patients with I-125 fibrinogen leg scans and 41 (29%) met the criteria for localized fibrinogen deposition consistent with venous thrombosis. He felt that low dose heparin prophylaxis for all stroke patients was not necessary. He recommended treatment with full dose continuous IV heparin for five days, and two months of coumadin anticoagulation in patients with positive I-125 fibrinogen study. By this method, he felt the risk and related expense of prophylactic subcutaneous heparin in all patients could be avoided.

In our study group, none of the patients were prophylactically anticoagulated. One patient developed DVT and was treated with subcutaneous heparin, as the patient had recent intracerebral hemorrhage. The patient developed PE, although he was on subcutaneous heparin for one week. To decide on prophylactic anticoagulation in these patients without adequate justification was highly questionable, even on a retrospective analysis, because of the risk of anticoagulation. Most reports[1,5,12] show 3% to 8% incidence of major bleeding as a complication of anticoagulation.

Thirteen of 15 (87%) of our patients treated with heparin and coumadin for PE did not develop any complications related to anticoagulation.

Summary

In stroke patients studied retrospectively, 4.1% incidence of PE (15/363) was noted; 20% of patients who developed PE had clinical evidence of DVT. Chest pain, dyspnea, and fever were common symptom complexes. Definitive diagnosis was delayed when fever was the only presenting symptom. Results of chest X-rays and ECGs were nonspecific but helpful in excluding other causes of symptoms. Lung scans (V/P) were positive in all cases. None of the patients were prophylactically anticoagulated. No special studies were used to identify DVT in these patients.

Further analytical studies regarding actual incidence of DVT and PE in stroke patients, the role of prophylaxis, risks involved, and duration of anticoagulation to adequately protect the patients from further episodes of embolization are needed. These should be done on a prospective basis in large patient populations to enable proper conclusions. ◀

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Registration and Education

The following disciplinary orders have been received from the Department of Registration and Education:

Medical Disciplinary Board

- *Lewis C. Powell, M.D.* (license # 036-030645): On January 9, 1984, an order was signed that Dr. Powell's license would remain in good standing, although in a non-renewed status.
- *Frances Noecker, M.D.* (license # 036-034490): Effective February 26, 1984, the medical license of Dr. Noecker was ordered suspended for 5 years.
- *Herbert John Rohr, M.D.* (license # 003-036-036693): On March 15, 1984, the medical and controlled substance licenses of Dr. Rohr were placed on probation for a period of one year, with certain provisions to be met prior to having his license restored.
- *Robert Bevier, M.D.* (license # 036-056661): On March 14, 1984, the license of Dr. Bevier was suspended indefinitely.
- *Arthur Polussa, M.D.* (license # 003-036-66885): In February, the controlled substance license of Dr. Polussa was summarily suspended.
- *Ralph Seward, M.D.* (license # 036-030082 and # 003-036-030082-1): On March 29, 1984, the medical license of Dr. Seward was placed on probation for a one-year period, subject to certain provisions. At the same time, the physician's controlled substances license was suspended for 90 days, with that suspension stayed, pending the successful completion of the probationary period.
- *Avner Kauffman, M.D.* (license # 003-036-030820-1): On April 5, 1984, the controlled substance license of Dr. Kauffman was summarily suspended.

(Source: Final orders of the Director of Registration and Education)

From the Department on Aging

- The Illinois Department on Aging reports that Case Coordination Units and hospital discharge planners are successfully linking hundreds of elderly referrals with community services. Since July, 628 patients age 60 and older have been discharged from hospitals to community programs instead of nursing homes. The Department reports that most of the 930 referrals each month are screened within three days of the referral.
- To date, some applicants have been denied Community Care Program services because of failure to obtain the required physician's statement. However, in many more instances, lack of physician's approval is delaying services for applicants, especially in metropolitan areas. Case Coordination Units in many cases are visiting physicians' offices to pick up the required form.
- Questions about the client's care plans or about the physician statement should be directed to the Case Coordiantion Unit identified on the form.

(Source: Correspondence from DOA Public Information Officer)

From the Department of Public Health

Hospital Licensing Board

- At a recent meeting, the Illinois Hospital Licensing Board approved the attendance of husbands and fathers in Caesarean sections of the wives/mothers, but denied a request to permit "significant others" to attend such surgeries. Attendance of husbands/fathers is at the discretion of the hospital; it is not mandated.
- The Board is also considering how and if physician employees should be permitted to function within a hospital.
- The Board denied a request to permit a hospital to create an exclusionary list of surgeries where tissue would not have to be examined. The Board's decision was to retain the current requirement that all tissue removed from surgery must be examined, although the extent of the examination is determined by the pathologist.

(Source: Feb. 22, 1984 Hospital Licensing Board Meeting)

ISMS Legislation Attacks Professional Liability Problem

The Illinois State Medical Society launched its legislative drive to attain professional liability reform last month. Success was threatened almost at the outset, however, when the legislation was referred to lawyer-dominated committees for hearing.

By the end of April, the Society had cleared the first major hurdle when the House and Senate Rules Committees voted to consider the professional liability legislation an "emergency." Special committee action was necessary because the current session is limited to fiscal and emergency measures.

Should opponents of the legislation be successful in blocking the legislation in this session, ISMS will respond with a multi-faceted public education campaign to generate support for an all-out effort to pass reform legislation during the 1985 session.

Major elements of the society's 11 bill legislative package include:

- A proposed cap on non-economic damage awards, such as those for "pain and suffering" and "loss of consortium;"
- Easing restrictions on countersuits and recovering defense and court costs;
- Reduction of damage awards by the total amount of funds received from other sources (*e.g.*, medical insurance);
- Structuring of settlements to reduce "up front" awards and windfalls to survivors;
- Early dismissal of plaintiffs not actually involved in a malpractice incident;
- Establishment of pre-trial screening panels and
- Guaranteed fair share of awards to patients through sliding scale limits on contingent attorney fees.

Companion bills incorporating the above proposals were introduced in both the Senate and House. Sponsoring various elements of the ISMS legislative package in the Senate were: Senators Prescott Bloom (R-Peoria), Terry L. Bruce (D-Olney) and Aldo DeAngelis (R-Chicago Heights). House sponsors were: Reps. Robert W. Churchill (R-Lake Villa), Loleta Didrickson (R-Homewood), Thomas Ewing (R-Pontiac), Ted E. Leverenz (D-Maywood), Thomas McCracken (R-Downers Grove), Josephine Oblinger (R-Sherman), Alfred G. Ronan (D-Chicago), Thomas Ryder (R-Jerseyville), Michael Tate (R-Decatur), Sam Vinson (R-Clinton), Ronald A. Wait (R-Belvidere), Jesse White (D-Chicago) and Jill Zwick (R-West Dundee).

Society Holds News Conference

During a news conference timed to coincide with the introduction of the legislation, ISMS President Dr. Robert C. Hamilton told the legislative press corps that "the spiralling cost of medical malpractice insurance has reached crisis proportions for the state's practicing physicians."

Dr. Hamilton cited a recent opinion poll commissioned by the medical society which revealed that more than three out of four Illinois physicians (78%) cited malpractice-relat-

ed concerns as the most critical issue facing the medical profession today. Many physicians polled by the society compared the current situation to that of 1976 when a volatile legal climate forced Illinois physicians to form their own insurance company in response to commercial carriers leaving the Illinois market. "Of those physicians surveyed who were practicing in Illinois in 1976, some 74% believe the situation today is as serious as it was then," Dr. Hamilton emphasized.

Legislators Give Support

In addressing the ISMS legislative package, Sen. Bloom said, "I believe that we must put a review of the malpractice portion of our tort system on the public agenda."

Sen. Bruce called the society's proposals "a reasonable attempt to put balance back into the system" for handling medical liability complaints.

Echoing Sen. Bruce's comments, Rep. Vinson said he was convinced that "the physicians of Illinois are not seeking a special place under Illinois law, but merely fair and equitable treatment."

"Patients harmed by negligence of physicians should receive just compensation," Rep. Vinson said, "but the current legal climate has progressed to the point where the situation is out of control." As evidence, Rep. Vinson pointed to results of the ISMS opinion poll which indicated that nearly half of the state's physicians have been sued for malpractice.

"We believe the medical society's legislation should be considered an emergency and therefore acted upon during the current General Assembly session," said Sen. DeAngelis.

"The bills introduced by the medical society are of critical importance in addressing the problem of rapidly increasing costs for medical care. The medical liability situation is a major factor in rapidly increasing health care costs," Sen. DeAngelis said. "Escalating malpractice insurance premiums, skyrocketing damage awards by juries, higher legal bills for defending frivolous claims, and the costs of 'defensive' medicine are placing a serious burden on society as a whole."

Costs Emphasized

Addressing the cost issue, Dr. Hamilton emphasized that medical malpractice insurance premiums charged by the Illinois State Medical Inter-Insurance Exchange (ISMIE), the state's physician-owned carrier, have risen 127% since 1976. The cost of malpractice protection for a surgeon insured under the ISMIE program can be as high as $48,000—a cost which must be passed on to the physician's patients. Additional premium increases are expected for ISMIE's next premium year which begins in July.

"The rise in premiums is attributable to both the number and severity of claims being filed," Dr. Hamilton said. "By the end of 1983, suits filed against physicians in Cook County had risen 220% over the number filed in 1977," he said. "The problem of frivolous suits is underscored by the fact that only about 20% of the claims closed by ISMIE since the company's inception in 1976 have been closed with any payment," Dr. Hamilton emphasized. He added that physicians were victorious in 82% of the cases that went to trial in Cook County in 1983.

Meanwhile, the size of damage awards and claims settlements continues to rise dramatically. "The average payment by ISMIE has reached $132,000, nearly double the 1980 average of $68,000," Dr. Hamilton said. Total damage awards in Cook County for the *three* years 1981-83 were $39.2 million—nearly double the $20 million awarded during the previous *eleven* years.

Lawyers Upset

The controversial nature of the ISMS legislative package was apparent immediately upon its introduction. The Illinois Trial Lawyers Association attempted to pre-empt the ISMS announcement with a press conference of its own. A statement released to the press by the trial lawyers attacked the Illinois State Medical Inter-Insurance Exchange, claiming that "doctor-insurers deceive themselves and the public." The trial lawyers' attack served to heighten interest in the issue on the part of the state's news media.

The trial lawyers' association is expected to continue its stiff opposition to the ISMS proposals, but the society has vowed to push its effort for reform until adequate legislative relief is obtained. ◀

Highlights of the ISMS Professional Liability Legislative Package

The proposed legislation developed by the Illinois State Medical Society to address the professional liability problem attempts to do so in a fair and reasonable manner. The Society's bills are not intended to prevent those truly injured by medical malpractice from being compensated in a just fashion, and in fact, actually create safeguards to guarantee that the rights of those harmed are protected.

The ISMS proposals are designed to materially reduce future increases in medical liability costs, thereby helping to reduce the overall rate of inflation in health care costs. The reforms are centered around three major objectives for reform.

- Limits on windfall recoveries which go beyond that necessary to provide fair compensation.
- Mechanisms for the early and inexpensive disposition of unfounded medical malpractice claims.
- Procedures to discourage the filing of frivolous claims.

Following are the major provisions of the 11-bill package which was introduced by ISMS on April 11:

A limit of $100,000 on recovery for non-economic damages

A substantial portion of medical malpractice awards are for intangible items of non-economic damages such as "pain and suffering" and "loss of consortium". These non-economic items are difficult to quantify in terms of accurate or even approximate monetary terms.

The ISMS legislation would limit to $100,000 recovery for such non-economic losses. However, the proposed reforms would not impair an injured party's right to be awarded compensation for full economic losses sustained, (*i.e.* loss of earnings, future earnings capacity, costs for medical care and costs for future medical care).

Punitive damages in medical malpractice cases also would be prohibited under the ISMS proposal.

Periodic payment of large judgments

The ISMS legislation would allow courts to make use of periodic payments to satisfy large judgments rather than directing that an entire award be paid immediately. A primary advantage to periodic payments is that insurance carriers could purchase annuities which are less expensive than lump sum payments.

Structured payments also would guarantee that funds would be available in the future for the injured party's future needs. Additional protection would be provided by preventing misuse of lump sum payments by guardians or persons ill-equipped to handle large sums of money.

Under the ISMS proposal, structured payments would be adjusted for inflation and the judgment debtor would be required to post adequate security. Windfalls to unintended third parties would be prevented by providing for termination of payments for future non-economic loss and medical expenses upon the death of the patient.

Itemization of jury verdicts

Juries in medical malpractice cases would be required to itemize damage awards under the ISMS legislation. The portions intended to cover past and future losses for medical care, lost wages or earning capacity, and other economic losses claimed by the patient would have to be stated specifically. Itemization is intended to cause juries to be more focused in their deliberations

on potential damage awards and to discourage inflated lump sum awards.

Elimination of the "collateral source rule"

ISMS' legislation would allow judgments in medical malpractice cases to be reduced by collateral source payments (*i.e.* medical insurance) received by the injured parties. While Illinois law currently recognizes the fairness of accounting for payments from other sources, the law provides that such payments cannot reduce judgments by more than 50%.

Use of pre-trial screening panels

Pre-trial medical review panels would be established to initially review and make recommendations to the court regarding the validity of malpractice claims. Each panel would consist of a judge, attorney and physician, and panel decisions would not be binding on the court. However, in the case of a unanimous decision by the panel, a party choosing to pursue an adverse decision would be liable for the other side's attorney fees and court costs if his or her arguments did not prevail at trial.

Early dismissal of claims against physicians erroneously named in malpractice suits

To resolve the problem of "shotgun" suits which frequently name physicians with no involvement in alleged incidents, the ISMS legislation would allow defendants erroneously named in a medical malpractice case to be dismissed upon filing a simple affadavit denying all direct and indirect involvement. The dismissal could be opposed or vacated if the plaintiff could show that a defendant was involved. Reform in this area is intended to reduce direct litigation costs as well as the indirect costs of practice time lost when an uninvolved physician is forced to give depositions and testify at trials.

Penalties for pursuing frivolous malpractice claims

Under the ISMS legislation, a plaintiff or attorney who makes untrue allegations without reasonable cause would be liable for attorneys' fees and other costs incurred in challenging the untrue allegations. The financial risk imposed upon the plaintiff should significantly reduce the incidence of nuisance suits which can be costly to defend. The ISMS legislation also would remove the requirement that victims of malicious prosecution prove special damages.

Guarantees that patients receive appropriate awards through a sliding scale limit on contingent attorney fees in medical malpractice cases

A reasonable, sliding scale for attorney contingency fees could lead to a reduction in the size of medical malpractice awards and would help insure that damages are used for their intended purpose. Courts could modify these limits in extraordinary cases.

Contingent fee arrangements in medical malpractice cases would have to be in writing and filed with the court along with an affidavit stating that the attorney has not unethically solicited the case. Similar rules have been adopted by the U.S. District Court for the Northern District of Illinois with respect to personal injury actions.

Restrictions on expert witnesses

The ISMS legislation would change qualifications necessary for expert witnesses. Physicians testifying would have to be devoting at least 75% of their professional time to the active clinical practice of the defendant's specialty, the instruction of that specialty in an accredited medical school, or a combination of the two. ◀

Physician Recruitment

(Continued from page 323)

PITTSFIELD:
Population 4,200; County: 19,500. 67 bed JCAH accredited hospital completing $2 million addition/renovation in May 1984. Ten active staff members at present. Openings in Family Practice and General Surgery. 75 miles west of Springfield between Illinois and Mississippi Rivers. Recreational facilities abound. Contact: Fred Thompson, 640 W. Washington Street, Pittsfield, 62363, 217-285-2113. (5)

SALEM:
Population 7,800. 70 miles east of St. Louis, immediately off I-57. Need OB-GYN physician to join existing corporation or to practice independently. Existing corporation provides renovated office building less than five minutes from 65 bed JCAH accredited hospital. Guaranteed salary. Contact: Thomas G. Walther, Adm., Salem Hospital, Salem, 62881, 618-548-3194. (4)

STREATOR:
Community of 22,000, serving population area of 70,000. Located 60 miles from Joliet and Peoria. Fully equipped hospital of 248 beds, with 41 physicians on staff. Cardiology, psychiatry and family practice specialities needed. Practice guarantees provided. Interested physicians are asked to send current resumes to: Terence Schuessler, Adm., St. Mary's Hospital, 111 Spring Street, Streator 61364. (4)

A Delicate Balance

ISMS Guide To Hospital Medical Staff Bylaws

At its September, 1983, meeting the ISMS Board of Trustees approved and mandated publication of the "ISMS Guide to Hospital Medical Staff Bylaws."

This document was developed by the Ad Hoc Committee on Resolution 37 (A-81), a subcommittee of the Council on Medical Services Members of that subcommittee, chaired by Wallace Berkowitz, M.D., were James R. DeBord, M.D., C. Larkin Flanagan, M.D., Allan L. Goslin, M.D., A. Beaumont Johnson, M.D., Donal D. O'Sullivan, M.D. and David Whitney, M.D.

It is hoped that this guide will help physicians to balance the many complex issues confronting hospital medical staff members. As demonstrated at the November, 1983, ISMS Leadership Conference, today's physician must juggle many roles. This guide is intended to assist the physician who seeks to meet his responsibilities and exercise his rights in the professional context.

This feature is the second in a series initiated last month, which will continue over the next several issues. The first portion, in the April issue (page 256) covered introductory material and draft Articles I-III. This month's segment will cover Articles IV-VII. In June, the concluding sections will be published. Later this summer, the "Legal Considerations of Medical Staff Bylaws," appendix referenced in the text will complete the series.

ARTICLE IV. DISCIPLINE

All Staff members functioning within the hospital, including those employed by or under contract with the hospital, are to be covered by the provisions and due process protections of these bylaws, any provision of individual employment or contract notwithstanding.

GENERAL COMMENTS

The introductory section of the disciplinary chapter of a Medical Staff's bylaws should clearly describe who is covered by its provisions. Without such language, a hospital may attempt to exclude certain categories of practitioners from the protections contained in the bylaws.

JCAH RECOMMENDATIONS

The bylaws are to provide a mechanism for corrective action and automatic and summary suspension.

Section A. Complaints

Complaints against a member of the Medical Staff may be submitted by any person, in writing only, signed by the complaining party and directed to the Chief of Staff, a Department Chief, the Chairman of any standing committee, the Medical Executive Committee or the Administrator of the Hospital.

If a complaint is not directed to the Chief of Staff, a legible

photocopy of the complaint shall be given to him within ten working days of its receipt for his appropriate action and/or referral.

To be accepted for consideration, the complaint must describe, in detail, any allegations in a bill of particulars.

GENERAL COMMENT

Complaints can be initiated by practically anyone in the Hospital. To prevent vague, indefinite charges being brought, which are difficult for the accused to defend, the bylaws should require that *written* complaints be drafted as a bill of particulars. This helps to clarify the issues for the reviewing body, and gives the accused the opportunity to develop an appropriate defense and to know his accuser.

The staff member complained of will be promptly notified by the elected Medical Staff Secretary of the existence of, and the nature of, any complaint made against him by providing him with a legible photocopy of the complaint, by certified mail, within ten working days of the receipt of such complaint by the Chief of Staff.

In no case will a complaint or information file be kept concerning a staff member by any component of the Hospital or of the Medical Staff without the member being notified in writing of the existence of such a file and of his right to examine such a file at any reasonable time during ordinary working hours and to obtain photocopies of any or all the contents of that file for his own use at no expense to him.

GENERAL COMMENTS

This section prevents the development of a file held only by hospital administration. Without proper notice, the accused is denied the opportunity to answer, clarify or investigate the complaint.

Section B. Investigation and Action

All complaints alleging clinical incompetence will be referred to the appropriate Department Chief for evaluation, and appropriate action.

GENERAL COMMENTS

Only the clinical Department and the *physicians* in that Department are qualified to evaluate such a complaint. This provision further precludes complaints generated by administrative conflict—as with a member of the nursing staff—from being mislabeled as a *clinical competence* complaint.

Complaints not related to a staff member's clinical obligations will be reviewed by the Chief of Staff and referred or dealt with as deemed appropriate.

Section C. Action by the Illinois Medical Disciplinary Board

Should the Hospital verify or receive actual notification from the Illinois Department of Registration and Education of a Medical Staff member's revocation or suspension of a license, the named person's staff privileges shall automatically terminate unless the Department of Registration and Education "stayed" such suspension or revocation.

Such stayed revocation, suspension or probation by the Department of Registration and Education may be sufficient grounds for termination of Staff membership and/or privileges, or probation for an indefinite period of time. Such action is to be determined by the Medical Executive Committee. The probation may be extended beyond the time period set by the State of Illinois.

GENERAL COMMENTS

Hospital staffs should request the Department of Registration and Education to send them the monthly newsletter of state disciplinary actions against physicians and other health personnel.

Medical Staff action, in response to disciplinary action by the state affecting a member's privileges, will be separate and distinct from any Hospital action taken by the Administrator or by other Hospital officials.

Section D. Summary Suspension

In grave and unusual cases, the Governing Board may take immediate action to protect a patient's life or welfare by summarily suspending the privileges of a member of the Medical Staff, as long as the Board acts in concert with the Chief of Staff, the Department Chief (or their designees) and the Administrator.

GENERAL COMMENTS

It is recognized that such summary action may, at times, be necessary. This clause defines the method by which such summary action may be taken without avoidable error. The provision also mandates that each staff position (Chief of Staff, Department Chairman, etc.) be "covered" 24 hours a day by the incumbent or by either his stated deputy or by another physician competent to act in his place and available to the hospital.

JCAH RECOMMENDATIONS

The bylaws are to provide for a mechanism for corrective action and automatic and summary suspension.

The Medical Staff will not recognize any summary action taken by the Hospital to suspend or remove privileges which was done without consultation with the Chief of Staff or his designee.

GENERAL COMMENTS

This inhibits arbitrary and capricious action by the Hospital.

The suspended party may request a meeting of the Medical Executive Committee, to be held as soon as possible, but in no case more than 72 hours, after such summary suspension takes effect, to determine whether the suspension shall continue. The MEC may refer the matter to an appropriate committee for subsequent review.

The Chief of Staff shall make the necessary arrangements to provide alternate medical coverage for proper and necessary patient care during the period of suspension. Each patient's wishes should be considered in providing alternative coverage.

Section E. Limited Suspension for Incomplete Medical Records

Suspension of *admission privileges,* effective until medical records are completed, may be imposed automatically for failure to complete medical records within ———— days of a patient's discharge and after proper notice of at least ———— days. Such suspension may be relieved by the medical records department or by the Chief of Staff upon showing of good cause for the deficiency or by completion of the records.

GENERAL COMMENTS

This is a purely administrative and routine "police" action that should be handled routinely. It should be noted that only *admitting* privileges can be suspended in such fashion. The practitioner concerned is expected to continue his care of already admitted patients. To do otherwise would transfer liability for abandonment from the staff member to the Hospital in a situation where neither should have it.

ILLINOIS REQUIREMENTS

The staff must provide for keeping complete medical records. (3-1.1.m.)

Section F. Hearing Process

1. Request for Hearing and Notification

Whenever an adverse decision has been made against a person's Staff application, status or privileges, or he has been accused and found in violation of these bylaws or hospital practice, he shall have the right to request a formal hearing.

ISMS POLICY

A member of a Medical Staff should receive due process, as spelled out in his bylaws, before his Staff privileges can be terminated. ISMS supports physicians in their right to continue practice in a community or hospital as long as they follow the bylaws of the Medical Staff and maintain the highest quality of medical practice to their patients, unless good cause can be shown that a condition of their practice is not in the best interests of their patients.

Physicians whose Medical Staff appointments are terminated or whose hospital privileges are reduced are entitled to basic due process guarantees, including knowing the specific charge, having adequate notice of a hearing, having the opportunity to submit and hear evidence and having the right to present a defense before an impartial body. For further information on due process provisions, see the ISMS publication, "Due Process Guidelines for Physicians."

LEGAL CONSIDERATIONS

Chapter III, p. 5-8
Chapter V, p. 13-15

JCAH RECOMMENDATIONS

The bylaws are to provide for the establishment of fair hearing and appellate mechanisms when requested by a practitioner in connection with Medical Staff recommendations for denial of staff appointment, denial of reappointment, or the curtailment, suspension or revocation of privileges. It is recognized that the mechanism for individuals applying for initial staff appointment or privileges may differ from that applicable to current staff members.

A JCAH monograph suggests that these mechanisms specify:

1. the period of time beyond which the right to request a hearing is waived;
2. the right to introduce witnesses or evidence;
3. the role, if any, of legal counsel and
4. fixed periods of time to complete each action, including final action by the governing body.

Within ten working days after the receipt of a request for a hearing, the Chief of Staff shall schedule and arrange a hearing and shall notify the applicant or member by certified mail of the date, time and place of the hearing. Such notice shall set forth a hearing date which should be not less than fifteen nor more than thirty days from the date of the receipt of the request for the hearing, or on such other date as can be mutually agreed upon.

This notice shall state the specific acts or omissions complained of and giving rise to the action.

GENERAL COMMENTS

This ensures that the member of the Staff is put on notice that an adverse action is pending and allows him to prepare to defend himself.

Summary Suspension

When a member has been summarily suspended, the hearing of any appeal should be initiated as expeditiously as possible, but in no case more than 72 hours after the suspension has taken effect.

GENERAL COMMENTS

Since summary suspension of clinical privileges may have a devastating or serious effect on a person's practice, public image and personal emotional state, it is an action that must not be taken arbitrarily or capriciously by any element of the Hospital structure. Furthermore, since it is an irrevocable step, once taken, with potentially extensive effects—the appeal mechanism must act promptly and thoroughly, to minimize any damage to the person if, indeed, such suspension was not warranted. Since, in any case, such action may result in a lawsuit against the hospital, or the Medical Staff, or the individuals who acted in the matter—such prompt action will also minimize the possible damage to the accused.

2. Investigation Team

The Chief of Staff shall appoint an Investigation Team made up of at least three Active Staff members to gather information relating to the issues to be considered by the Review Committee. The person who is the subject of the hearing shall have the right to challenge the members of the Investigation Team for reasonable cause.

A report on the team's findings shall be forwarded to the Review Committee for its consideration at least one week prior to the hearing date.

GENERAL COMMENTS

This is a critical phase, as the details of the situation are evaluated by a committee or individual chosen by the MEC. A lot of value judgments are made by the team, such as whether charts are to be reviewed or details collected. Interpretation of data and conversations vary greatly.

The accused should have the right to challenge the make-up of the Team for reasonable cause, such as personal or professional conflicts. He should also be permitted to have one individual favorable to him comment on the information.

3. Review Committee

When a hearing is requested, the Chief of Staff, with approval of the MEC, shall appoint a Review Committee of five Active Staff members who have not taken part in formal consideration of the contested matter.

If the allegation is from a Medical Staff department and involves competence, a majority of the Review Committee should be from the specialty involved.

The MEC may go to the local professional society for appropriate specialists to serve on the Review Committee, if such specialists are not available on the Staff.

The Review Committee shall elect a hearing officer from its members to preside over the hearing.

GENERAL COMMENTS

The hearing body should be absolutely impartial, with none of its members having anything to gain personally or professionally from the accused's dismissal from the staff.

No member of the Hospital's administration may be present at the hearing unless specifically invited by the Review Committee or as a witness, and then only for the time required for testimony and cross-examination.

GENERAL COMMENTS

This clause makes explicit the point that charges and defenses concerning competence or ethical conduct are a *professional* matter and a layman has NO PLACE in these deliberations. Since subtle, or not so subtle, pressures can be applied to the members of the hearing panel by the mere presence of the Administrator—it is necessary to exclude him from the deliberation and judgment process, to provide an environment in which justice can be done. This also protects the accused from spurious charges against his clinical ability which, in reality, are based on his personality or "ability to work well with others."

When the Adminstrator of the Hospital, acting in his capacity as a representative of the Board, is the party bringing the complaint, he may remain at the hearing as the complaining party; but in no case may he be present during the Executive deliberative sessions of the Review Committee nor may he, directly or indirectly, participate in the deliberative process of the Committee. Violation of this provision of these bylaws will NULLIFY and MAKE VOID the executive proceedings of the Committee and a new hearing, with a new Review Committee must be convened to hear the complaint.

Should a Medical Staff committee or Department initiate the action, it shall appoint a representative to document complaints and answer questions posed by the person accused or by members of the Review Committee.

4. Representation

The person who is the subject of the hearing may be accompanied at the hearing by a member of this Staff or by a member of his local professional society.

The person may have legal counsel help prepare his presentation as well as attend the Review Committee hearing to advise and to represent him.

GENERAL COMMENTS

The hearing phase is crucial to the accused, and without legal counsel he is truly unprepared. The Review Committee will have access to the Hospital's legal counsel and will probably receive instructions and advice from that attorney prior to and during its deliberations.

Since any hearing on privileges is only the first step that the accused physician must take in a long road toward final judicial detemination of his case in a courtroom, it is wise to allow him to involve his legal counsel at the earliest possible time. If he is in the right, this will then become clear to the hearing panel at an early stage. If he is in the wrong, his lawyer will advise him of the above situation—again at an early stage and prevent prolonged and fruitless actions.

5. Hearing Procedures

The presiding hearing officer shall determine the procedure and shall rule on the admissibility of evidence, not based on legal rules of evidence, but as a reasonable person conducting serious business.

Any participant may: testify and/or call witnesses to testify; examine the opposing participant or witnesses called by him; and submit exhibits or other physical or documentary evidence.

GENERAL COMMENTS

The hearing should be restricted to the parties, their witnesses, the members of the Review Committee and any legal counsel and court reporters requested by any of these participants. The hearing should be controlled by the presiding officer to avoid altercations and to proceed with business. There should be NO audience of non-participants (wives, children, non-involved hospital employees, or members of the general public—all such persons can attend the trial in a courtroom if such eventuates).

All witnesses shall be sworn under oath.

GENERAL COMMENTS

There is something about taking an oath that makes testimony more valid and places an obligation on the witness.

The scope of the hearing may extend to any relevant matter affecting professional competence and should consider all evidence produced by either party.

GENERAL COMMENTS

The report of the Investigation Team should serve as the focus of the hearing as it should have reviewed all allegations and information available.

Improper or inadmissable evidence, not pertinent to the issues to be resolved, should not be considered.

An adequate verbatim record of the proceedings shall be made by a tape recording or by a court reporter, or both. The party requesting a court reporter shall bear the cost of that service; however, the opposing party may purchase a copy of the transcript. The record shall contain any exhibits submitted by the parties, and be retained for five years. *Any participant* may record the proceedings for his own proper use.

ILLINOIS REQUIREMENTS

The Medical Studies Act states that records of hospital peer review proceedings and the like are privileged and strictly confidential (Ill. Rev. Stat., Chap. 110, Sec. 8-2-101).

The hearing may be continued to another date on the request of one of the parties. The requesting party's need for a delay should be accompanied by a written statement of explanation and justification.

The Review Committee shall enter a finding based upon a preponderance of the evidence presented.

6. Decision

Within ten days after the hearing, the Review Committee shall make its report and recommendations in writing to the MEC. The report may recommend affirmation, rejection, or modification of the original recommendation or decision on a person's membership application or reappointment.

If a complaint is found to be justified, the Review Committee may recommend probation, reprimand, rehabilitation, re-education, suspension, expulsion, loss of privileges or status, or supervision.

GENERAL COMMENTS

The hearing body should have several options to choose from and not be limited to denial or removal of privileges. In a complaint hearing, the punishment should fit the crime. Removal or restriction of privileges should be used only for fair and just reasons, since this may result not only in loss of prestige and income, but, in an action involving a physician, is also reportable to the state Medical Disciplinary Board.

At its next meeting, the MEC shall consider the Review Committee's report and if it concurs, forward it to the Governing Board. The MEC may return the Committee's report for clarification, to be completed within 2 weeks. The MEC shall then forward the reconsidered report along with its recommendation to the Governing Board within 45 calendar days of the date of completion of the Review Hearing.

The Governing Board should act at its next meeting and notify the MEC of its decision. If the Governing Board's recommendation is contrary to that of the MEC, a Joint Conference Committee of equal MEC and Governing Board members should meet to discuss the disagreements.

Within thirty days of receipt of the MEC's recommendation, the Governing Board's final action should be transmitted to the elected Secretary of the Medical Staff who shall forward, by certified mail, the decision to the parties.

Section G. Governing Board Appeal

1. Request for Appeal

Within ten days of receipt of an adverse decision from the Governing Board, the applicant may request an appeal. The request must be in writing, sent by certified mail to the Administrator.

If no timely request for a hearing on appeal is received by the Board, the Board's action shall be considered final by all parties.

Upon receipt of an appeal request, the Board shall notify the appeal applicant, by certified mail, of its consent to an appeal, its time and place. Such date shall be not less than fifteen nor more than thirty calendar days from the date of the receipt of the request for an appeal, or at such other time as may be mutually agreeable to the parties.

GENERAL COMMENTS

The right to appeal should be automatic where the person's staff membership or appointment is at stake.

2. Procedures

The applicant for appeal may be represented by legal counsel, and may give oral argument in support of his case. The Governing Board may, at its discretion, allow new evidence. A court reporter shall make a record of this appeal to the Governing Board.

The Board's final action will require a majority vote of the Board.

Failure of the appeal applicant to appear, absent good cause, and to proceed at such hearing, shall be deemed to constitute voluntary acceptance of the original recommendation and decision of the Board.

ARTICLE V. IMMUNITY AND CONFIDENTIALITY

Section A. Immunity

Each applicant to or member of the Medical Staff shall waive, in writing, any right of personal complaint for damages against the Medical Staff, its members or agents, or against any witness or person who submits information about the

person to a representative of the Staff or Hospital, who acts in good faith and without malice in any proceeding, activity or committee of the Medical Staff.

GENERAL COMMENTS

This waiver should be part of the initial application for Staff membership. It should be noted that such a waiver does NOT protect a member of the Staff or other person who, in fact, acts with malice or without good faith. It is likely that the presence or absence of malice/good faith will be determined by a court proceeding.

JCAH RECOMMENDATIONS

The bylaws should provide for a statement by the applicant for privileges and membership, releasing from civil liability all those reviewing or providing information relative to credentialing, staff membership and privileges.

Section B. Confidentiality

Investigative materials, findings and hearing proceedings are to be maintained in confidence and disseminated only to the parties, members of the review bodies and others permitted access by operation of law.

GENERAL COMMENTS

The Illinois Medical Studies Act protects the confidentiality of proceedings of hospital medical staff committees designed to review and improve the quality of medical care.

ARTICLE VI. MEDICAL STAFF CATEGORIES

Practitioners who are awarded membership and privileges will be assigned to one of the following Medical Staff categories:

ILLINOIS REQUIREMENTS

The bylaws are to provide for such divisions as are warranted within the staff. As a minimum, active and consulting divisions are required (3-1.1.d).

GENERAL COMMENTS

The number and types of staff categories, beyond active and consulting, are at the discretion of the Staff. However, the category system should not permit a person to have any rights or privileges of an Active Staff member, while avoiding the responsibilities of a member of that category.

Bylaws should include the following for each category desired: eligibility requirements, voting rights, meeting requirements, office and committee eligibility, service responsibilities and, if appropriate, priority for patient admissions.

Section A. Active Staff

The Active Staff includes practitioners who are primarily associated with the Hospital and provide professional services within the Hospital on a regular basis. These staff members provide the preponderance of professional medical services furnished within the Hospital and undertake extensive responsibilities within the organization of the Hospital.

ILLINOIS REQUIREMENTS

Regardless of any other categories (divisions of the Medical Staff) having privileges in the hospital, there shall be an Active Staff which must include physicians and may also include dentists and podiatrists, properly organized. (3-1.2).

1. Qualifications

a. Active Staff members are expected to reside and maintain an office within sufficient proximity of the Hospital to provide continuing care to patients;

GENERAL COMMENTS

"Sufficient proximity" should be defined by the experience of the individual's practice and adequate promptness in responding to patient needs.

LEGAL CONSIDERATIONS

Chapter IV. A. p. 8

b. Members qualify for the Active Staff following not less than 24 months' service as a member of the Associate Staff;

GENERAL COMMENTS

This time period, and the others in these Bylaws, are designed to allow the new practitioner on the Staff adequate time to become familiar with the duties he may be called on to perform and the institutional characteristics of the Hospital and its Staff.

c. An Active Staff member is expected to regularly request admission of his patients to the Hospital;

d. Members in this category regularly assume the functions and responsibilities of this status, including committee assignments, offices and other services as defined in these Bylaws;

e. Physicians in this category are expected to have achieved the appropriate specialty board certification, be eligible to take the specialty examination, or have such experience and competence as recognized by the MEC; and

ISMS POLICY

The results of recertification examinations should not be the sole criteria used by hospitals in the granting of clinical privileges.

GENERAL COMMENTS

"Board Certification" was never meant to be and should not be a determining requirement for candidacy for Staff membership or privileges.

f. Active Staff Members will receive first priority for routine patient admission and service availability in the hospital.

2. Responsibilities

A practitioner appointed to Active Staff Status is responsible for the following:

a. Attending and voting at meetings of committees to which he has been appointed or elected;

ISMS POLICY

A hospital's Medical Staff should be an autonomous, self-governing body whose members participate in the activities of Medical Staff and Hospital committees.

b. Attending meetings of the general Staff and his department(s);

c. To continue to meet the requirements for Active Staff status as defined in these Bylaws;

d. To abide by all provisions of these Bylaws and all policies adopted by the Medical Staff;

e. To actively participate in activities of the Staff and Hospital related to maintenance of competent care and other appropriate Staff approved activities, including accreditation activities;

ISMS POLICY

The Medical Staff of a hospital should cooperate to achieve JCAH accreditation of their hospital.

f. To prepare and complete all medical and other records for each patient whom he serves; and

g. To provide care to all indigent patients for whom the member requests admission, attends or consults.

3. Senior Active Status

A practitioner who has served at least ____ full staff years as a member of the Active Staff or has attained the age of ____ shall, if thereafter appointed to the Active Staff, be eligible for Senior Active Staff Status.

The Senior Active Staff shall be part of the Active Staff and shall be included in all references to the Active Staff and have the same qualifications and responsibilities of the Active Staff member. However, Senior Staff shall not have to participate in mandatory rotational programs.

GENERAL COMMENTS

As a reward for growing old in service to the community on the *Medical Staff*, the senior practitioners may elect to avoid mandatory service activities.

Section B. Associate Staff

Associate Staff members are those practitioners who are primarily associated with the Hospital and provide other services as defined in these Bylaws. They provide services within the Hospital on a regular basis. They have advanced from Provisional status and have not yet attained Active status, as defined in these Bylaws.

1. Qualifications and Responsibilities

An Associate Staff member shall have the same qualifications and responsibilities as an Active Staff member, with the exception that an Associate Staff member cannot hold an elected Medical Staff office or vote, except within his Department. He may be appointed Chairman of a regular or ad hoc Medical Staff committee.

The Associate Staff status is a two-year classification prior to achieving full Active status. Associate staff shall automatically be advanced to Active Staff status following the Associate period, unless otherwise denied privileges by the Medical Executive Committee and Governing Board.

GENERAL COMMENTS

A provision requiring advancement in staff status ensures that the Medical Staff structure will be truly representative of the members of the Medical Staff. It is intended to prevent the capture of the Staff by a clique that maintains itself by denying full working privileges to groups of practitioners who are not part of the clique.

The Associate Staff member will receive secondary priority status for routine admissions and services in the hospital.

Section C. Provisional Staff

Persons who initially apply and have been accepted for staff membership and granted privileges are placed on the Provisional Staff. Those who have been placed in this probationary position shall not have hearing or appeal rights on the determination of their initial privileges or on the decision to retain them on staff. This category is used by the hospital Staff to observe the practice of a new member to determine if his performance equals his desired level of privileges.

Practitioners are placed in this category for a period of one year, or until the Medical Executive Committee finds the person has done a sufficient amount of work to be judged as to competency. In no case shall a person remain in this category longer than two years. Following the provisional period he will be advanced in status or terminated from the Staff. In the event that a practitioner on the Provisional Staff is terminated by the Medical Executive Committee, he may appeal the termination in accordance with Section IV G.

Members of the staff placed in this category shall be assigned a proctor to supervise and observe their work in the hospital during the provisional period. The Proctor shall advise the Provisional Staff member of observed deviations from customary practice at this hospital.

A Provisional Staff member shall have the voting rights and committee responsibilities of a member of the Associate Staff, but will have no vote at the Departmental or at the general staff level, or with respect to his own advancement or termination of status.

GENERAL COMMENTS

The major purpose of Provisional Status is to define the privileges to be granted. The final determination of initial privileges is a non-appealable decision.

As stated earlier, the provisional period provides the staff with an opportunity to observe and work with a new member. Following sufficient time, evidence will be available to document one's ability. It is inappropriate and unfair to keep a person on provisional status once this evidence is reviewed. The person is either providing quality care or is a danger to have on staff.

Section D. Courtesy Staff

This category includes persons who are primarily associated with another hospital but may request admission for and provide care to patients at this hospital.

GENERAL COMMENTS

This ensures that such practitioners are subjected to a peer review mechanism that meets JCAH Standards.

1. Qualifications and Responsibilities

The Courtesy Staff members are expected to meet the qualifications of Active members. They may request admission for a reasonable number of patients as shall be permitted from time to time by the MEC, with the approval of the Governing Board.

2. Obligations

Courtesy Staff members have neither voice nor vote at general Staff meetings. They may attend committee or Department meetings where they will have voice, but no vote. They have no obligation to attend any meeting of the Staff or any of its subdivisions, unless specifically invited.

GENERAL COMMENTS

Vote and mandatory meeting attendance go together. If mandatory attendance is not required of a person, neither should he have a vote; alternatively, if you do not give him a vote, he should not be required to attend meetings.

Section E. Consulting Staff

Consulting Staff includes practitioners who, while not primarily associated with the Hospital, provide Staff members with consultative services.

Consulting Staff must be active members of a JCAH (or American Osteopathic Association) accredited hospital.

GENERAL COMMENTS

This ensures that these practitioners are subjected to a peer review mechanism that meets JCAH Standards.

A Consulting Staff member receives or reasonably anticipates receiving requests for consultations from members of the staff.

Section F. Limited License Practitioners

Persons who are licensed to practice independently, in a limited fashion, and are permitted by state law to be members of medical staffs, shall be designated Limited License Practitioners, and shall be organized into staff sections, each composed of practitioners of similar licensure.

Each patient of a Limited Licensed Practitioner shall be admitted to the Hospital by the co-admission of such patient by a physician member of the Medical Staff and the Limited License Practitioner and will be (throughout his stay in the Hospital) the responsibility of a physician member of the Medical Staff for overall patient care.

ILLINOIS REQUIREMENTS

Regardless of any other categories (divisions of the Medical Staff) having privileges in the hospital, there shall be an active staff which must include physicians and may also include dentists and podiatrists, properly organized (3-1.2).

All persons admitted to the Hospital shall be under the professional care of a member of the Medical Staff. Patients admitted by a podiatrist or a dentist shall be under the care of both the admitting Medical Staff member and a physician who is also a Medical Staff member. The doctor of podiatric medicine or the doctor of dental surgery shall be responsible for all care within the limits of the privileges granted to him; the physician shall be responsible for all aspects of general medical care (3-2).

GENERAL COMMENTS

Since the Hospital, as an institution, has a duty to each patient admitted to ensure that medical diagnosis and care is rendered to him, and to avoid the development of occult disease as a significant factor during the hospital stay of the patient—each patient admitted must be the responsibility, for overall care, of a fully licensed practitioner member of the Medical Staff. This protects the Hospital from unforseen liability. It also allows the Hospital Board to decide what limited license practitioners it wishes to admit to practice in the Hospital.

JCAH RECOMMENDATIONS

The Medical Staff includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services without direction or supervision, within the scope of their licenses and according to individually granted clinical privileges.

ARTICLE VII. NON-MEDICAL STAFF CATEGORIES

Section A. Allied Health Professionals

Allied Health Professionals (AHP) shall include, but need not be limited to, duly licensed individuals other than physicians, whose patient care or diagnostic activities require that their authority to perform "specified services" be processed and their services be monitored through the Medical Staff functions.

GENERAL COMMENTS

This section provides for the mechanism to credential and monitor nurse practitioners, medical and X-ray

technologists, social workers and other health personnel who are licensed, certified or registered by the state and work in hospitals.

The Medical Executive Committee, with appropriate Medical Staff departments, may establish particular qualifications required of a specific category of the Allied Health Professionals.

Each applicant for specified patient care services or as Allied Health Professional shall be processed in the same manner specified for applications for membership and privileges on the Medical Staff as to the inspection and verification of credentials.

ILLINOIS REQUIREMENTS

Through the credentialing and/or privilege granting process, the Medical Staff shall ensure that a non-physician surgical assistant is qualified to perform his duties (3-1.1.p.).

JCAH RECOMMENDATIONS

The bylaws are to provide for a mechanism for delineation and retention of privileges, and reduction or withdrawal of privileges.

GENERAL COMMENT

Under these by-laws, the Medical Staff is given the responsibility of initially evaluating the credentials of any AHP. In addition, the Medical Staff may make decisions regarding continued status or privileges of an AHP.

Subject to the two limitations described below, in the event that there is an adverse decision on AHPs application, status or privileges, the AHP is accorded the same due process rights granted staff members in Section IV. The first limitation to this rule is for Staff members' employees (*i.e.*, AHPs not employed by the Hospital). It is felt that a physician should have the right to make decisions regarding his own employees without having that decision reviewed by others. The second limitation is that any determination made by the Medical Staff regarding the continued status or privileges of AHPs already employed by the Hospital shall be advisory only.

The ultimate decision and responsibility regarding hospital employed AHPs lies with the Hospital itself.

Whenever an adverse decision has been made by the Medical Executive Committee or by any member, committee, department or officer of the Medical Staff against an AHP's application, status or privileges, or an AHP has been accused of a violation of these by-laws or hospital practice, he shall have the rights provided for medical staff members in Section IV, provided, however, that a physician member of the Medical Staff may make such determinations regarding his own employees and such decisions shall not be subject to the procedures of Section IV.

Any determination regarding the continued status or privileges of an AHP employed by the Hospital (*i.e.*, one who is not a staff member's employee) shall be advisory to the Governing Board, which shall have the responsibility for determining the continued status or privileges of such AHP.

Each applicant must consent in writing to be bound by these Medical Staff bylaws and release from liability anyone acting for the Medical Staff, who acts in good faith and without malice.

An Allied Health Professional shall be assigned to the appropriate medical staff Department(s). He shall be ineligible for appointment to the Medical Staff committees and shall not vote or hold office. He shall be subject to supervision and review.

He shall provide specified patient care services under the supervision or direction of a physician member of the Staff.

Each Allied Health Professional shall retain appropriate responsibility within his area of professional competence for the care of each patient in the hospital for whom he is providing services, subject to continued monitoring by the Medical Staff, and shall exercise such responsibility and fulfill such obligations as may be designated from time to time by the Medical Executive Committee and by the Department(s) to which he is assigned.

An Allied Health Professional member may exercise independent judgment within his area of professional competence, and may participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care.

B. Employees of Staff Members

A physician member of the Active Staff may submit an application to have an employee of his practice assist him in treating and monitoring his hospitalized patients. Such personnel will be members of the Allied Health Professional Category of Staff, and are to be individually credentialed and privileged to function within the Hospital on completion of the process defined in Section A of this Article.

ILLINOIS REQUIREMENTS

The bylaws must provide for determining additional privileges of a staff member for the use of his/her employed licensed Physician's Assistant in the hospital, in accordance with the policies and procedures recommended by the Medical Staff and approved by the Governing Body (3-1.1.q.).

The Staff member requesting this additional privilege shall submit for review and approval by the Medical Staff and Governing Body: (a) the curriculum vitae of the identified Physician's Assistant and (b) written protocol with a description of the duties, assignments and/or functions, including description of the manner of performance within the hospital by the PA in relationship with other hospital staff (3-1.1.q).

Editor's Note:

The ISMS Guide to Medical Staff Bylaws will continue next month, beginning with Article VIII: Departments of the Medical Staff. The series will be carried over several issues and, on conclusion, copies of the complete document will be available upon request from the ISMS headquarters offices.

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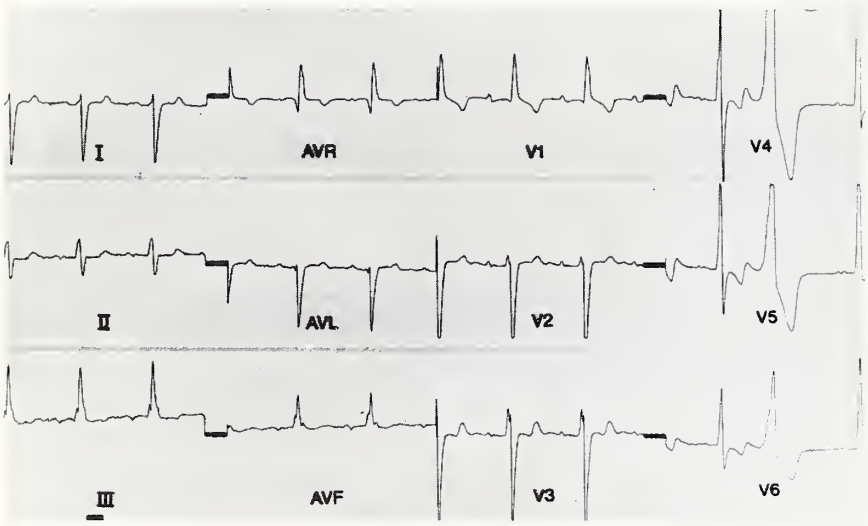
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a sixty year old man who was in good health until two days prior to admission. He had developed dyspnea in the early morning which awakened him from sleep. He had become diaphoretic as well. There was no chest pain or other discomfort. He had reported to his physician that afternoon. There were no coronary risk factors, eg., smoking, diabetes, hypertension, hyperlipidemia, or family history. His blood pressure was 130/58mmHg. His pulse was about 75 beats per minute and somewhat irregular. His lungs sounded normal except both bases were dull. There was a grade IV/VI crescendo/decrescendo systolic murmur at the base of the heart and a grade III/VI diastolic blow at the lower left sternal border. A loud ventricular gallop (S_3) was present. A chest X-ray showed cardiomegaly, and bilateral pleural effusions. The patient was admitted to the hospital and this electrocardiogram was obtained.

Questions:

1. **The twelve lead electrocardiogram shows:**
 a. Complete atrioventricular (AV) dissociation due to complete AV block.
 b. Complete right bundle branch block.
 c. Accelerated idioventricular rhythm.
 d. First degree AV block.
 e. Marked right axis deviation suggesting left posterior hemiblock.

2. **The following statement(s) is/are true.**
 a. An echocardiogram is indicated.
 b. A cardiac catheterization with consideration of open heart surgery is indicated.
 c. A pacemaker is required for heart block.
 d. The diagnosis is congestive heart failure.
 e. All of the above.

(Continued on page 360)

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Retrospective and Recommendations

By Susanne Webb, Immediate Past President, ISMSA

It has been an honor and a privilege to serve as the president of the Illinois State Medical Society Auxiliary. In looking back over the events of the past year, visits to the organized county auxiliaries have been one of the most rewarding aspects of the job. It has been a pleasure to become acquainted with individual auxilians and learn what each county auxiliary has been doing. The county auxiliaries *are* the Illinois State Medical Society Auxiliary. During these visits the president tries to learn how the ISMSA can be more responsive to the needs of individual members and auxiliaries. It is the goal of the ISMSA to serve the greatest needs of the largest number of members and one can only do this through communication and constructive criticism.

In making recommendations for the future, utilizing your state officers and chairmen would be at the head of the list. Call them for ideas; ask them to present programs at county meetings; correspond with them; *communicate.*

One of the most exciting new ideas to surface this year is the legislative internship program. This is a concrete example of a way in which we can be of assistance to our spouses, which is the primary goal of the auxiliary. Legislation increasingly affects all of our lives and we can learn to be a positive influence in getting responsible legislation passed. This also fulfills another goal of the auxiliary: to improve the quality of life and serve the health needs of our communities.

Most important, we need to get to know each other and to support each other. No one else understands our special and specific needs and problems quite as clearly. With few others can we find such empathy for our unique daily trials and joys. During my years in county, state and national auxiliary work, I have formed many treasured friendships that will last a lifetime. ◀

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(Continued from page 311

Diagnosis: Plasma Cell Granuloma

A wide variety of conditions are associated with thoracic masses in the pediatric age group (Table 1). The roentgenographic features of these masses help to narrow the diagnostic possibilities. Masses can be single or multiple and can be characterized by size, location, calcification, cavitation, and definition of margins. Masses may arise in the chest wall, pleura, mediastinum or lung. If the entire circumference of a mass is not visible, a pleural or mediastinal location should be suspected, since lesions in these locations are not completely surrounded by lung. A mass protruding from the skin surface may also cause a similar appearance.

Only four percent of *hamartomas* occur in patients under forty years of age.[1] The peak incidence is in the sixth decade and they are rare in children. The typical presentation roentgenographically is a pulmonary nodule, usually less than four centimeters in diameter, in the peripheral lung of an asymptomatic patient. The nodule is well circumscribed and its cartilage is calcified in 25-30% of cases.

Table 1
Thoracic Masses in Children

- Small Pulmonary Lesions
 - Granuloma
 - Extrinsic Allergic Alveolitis
 - Chicken Pox Pneumonia
 - Sarcoidosis
 - Miliary Tuberculosis
- Large Pulmonary Lesions
 - Pseudotumor
 - Plasma Cell Granuloma
 - Bronchopulmonary Sequestration
 - Primary Malignancy
 - Metastasis
- Anterior Mediastinal Lesions
 - Lesions of the Thymus
 - Hygroma
 - Desmoid
 - Hodgkins Disease
 - Pericardial Cyst
- Middle Mediastinal Lesions
 - Lymphadenopathy
 - Duplication
 - Bronchogenic Cyst
- Posterior Mediastinal Lesions
 - Extramedullary Hematopoiesis
 - Neurofibroma
 - Neuroganglioma
 - Neuroblastoma

Modified from
Rabinowitz JG. PEDIATRIC RADIOLOGY
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Intrathoracic masses may be simulated by *round pneumonias* in children. *Steptococcus pneumoniae* is the pathogen responsible for the majority of pneumonias of childhood which have a round masslike appearance, and the organism can often be cultured from the throat of the affected patient. The organisms are aspirated into the lungs from the upper respiratory tract and, like other aspiration pneumonias, the lower lobes and posterior segments of the upper lobes are most often involved. The organisms penetrate to the most peripheral air spaces where an inflammatory exudate is incited. The bacteria laden exudate is spread centrifugally via the pores of Kohn accounting for the homogeneity of consolidation and nonsegmental distribution.[2]

An aid in differential diagnosis of round pneumonia is recognition of the typical clinical presentation. Most often the child presents with the prodrome of a mild respiratory infection followed by a sudden acute febrile illness. Although classical pulmonary symptoms and signs are variably present, a polymorphonuclear leukocytosis is universal, as is rapid clearing of the radiographic density with appropriate antibiotic therapy.[3] A round pneumonia, as in the patient presented here, would not persist for more than one month.

Metastatic neuroblastoma may involve the liver, regional lymph nodes, skeleton, orbits, bone marrow and dura mater. Pulmonary metastases have been reported in up to 11% of patients coming to autopsy but the premortem description of pulmonary metastasis has not been well documented.[4] At least 11 patients have been reported in the literature with evidence of pulmonary metastases on chest radiographs. The radiographic patterns have included direct extension and lymphangitic and hematogenous spread.[4] In those patients presenting with hematogenous metastases, the lung nodules are most often multiple. In general, recognition of pulmonary metastasis has indicated widely disseminated disease and the rapid demise of the patient.

The pathogenesis of *plasma cell granulomas* is uncertain. A previous respiratory infection has been suggested as a predisposing factor. However, only 10% of patients can recall a previous infection.[5]

On gross pathological examination, plasma cell granulomas are usually firm and well-circumscribed. The characteristic color is yellow-white but some are grey, golden-tan or brown.[6] A few show evidence of hemorrhage, necrosis and true calcification. Microscopically, mature plasma cells are the major histologic component. In most of the lesions there are variable numbers of lymphocytes, large mononuclear cells and occasional polymorphonuclear leukocytes. Mast cells and eosinophils are occasionally found.[6] Scattered Russell bodies are often present among bundles of fibroblasts or with collagen and hyaline material.

Plasma cell granulomas may occur at any age. The oldest reported patient is 68 years and the youngest 13 months.[5] The lesion has been known by many other names, including post inflammatory pseudotumor, xanthoma, fibroxanthoma and xanthogranuloma, and is the most common solitary tumor like lesion of the lung in children less than 16 years of age.[6] Most of the patients are asymptomatic and the lesion is incidently discovered on a chest radiograph.

When symptoms are present, non-productive cough is the most common complaint. Other less common symptoms include dyspnea, hemoptysis and pain. No

physical findings are specific for plasma cell granuloma. Several patients have been reported with cyanosis at rest or on exertion, rales and rhonchi. Pleural effusion has not been detected and should raise suspicion about the diagnosis. Laboratory data contribute to the diagnosis in a negative sense. White blood counts are normal. Only a few patients have been reported with anemia. Skin tests and histochemical stains for tuberculosis, histoplasmosis, coccidioidomycosis and blastomycosis are invariably negative. Bacteria cannot be cultured from the lesions.

Radiographically, plasma cell granulomas most often present as solitary, circumscribed tumor-like masses of round or oval shape. They range in size from one centimeter in diameter to larger masses that may occupy a whole lobe.[5] The mass is usually sharply marginated but Bahador and Liebow described the margins of nine out of forty plasma cell granulomas as ill defined. Four of the forty cases were interpreted as atelectasis or pneumonia.[6] The lesions are seldom calcified. Central cavitation has rarely been reported. Either lung may be involved but the lower lobes are involved somewhat more commonly. Several cases of endobronchial plasma cell granulomas have been reported. Rarely there may be multiple lesions.

Plasma cell granulomas are usually surgically resected. Recurrence following surgical removal has not been reported. Bahadori and Liebow followed eleven patients with serial radiographs for 3 months to 4 years prior to surgery. Three of the eleven patients were stable for two years or more. The lesion increased in size in seven.[6] Mandelbaum, *et al*, advocate wedge resection for most plasma cell granulomas presenting as solitary pulmonary nodules. If wedge resection is impossible, they suggest adequate biopsy and if pathological examination is confirmatory, they recommend no further resection.[7]

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Adolescent females should be considered for rubella immunity testing. Susceptibility is defined as a hemagglutination antibody titer of less than 1:8. Subjects with history of vaccination showed 7.4% susceptibility, and the unvaccinated group had a susceptibility rate of 31.7%. Rubella is a benign disease except to the fetus, which suggests that physicians should evaluate the rubella immunity in females before they reach an age at which they may be expected to become pregnant. (Miller, K. A., Zager, T. D.: *Mayo Clin Proc* 59:31-34 Jan 1984.)

Closure of the foramen ovale occurs postnatally as the internal pressure in the left atrium becomes greater than in the right atrium. Generally this pressure gradiant variation closes the valves, which then fibrose and close this opening within the first year of life. Autopsies were performed in 965 normal hearts after age one, and 34.3% of cases showed patencies for ages up to 30 years, 25.4% to age 89 years and 20.2% between ages 90-100 years. The sizes of these openings tended to increase from 3.4mm in the first decade to 5.8mm at the 10th decade of life. (Hagen, P. T., *et al: Mayo Clin Proc* 59:17-20 Jan 1984)

A double blind study on 144 patients admitted to the hospital for acute myocardial infarction compared timolol and placebo on evolution of infarct size. Continuous vectocardiography and creatine kinase release were the criteria. Timolol started within four hours of onset of symptoms showed a 29.5% reduction in creatine kinase release and significantly smaller QRS-vector change. The initial ST-vector magnitude was reduced, as was the pain. The initial intravenous use of timolol is recommended for patients with suspected myocardial infarction. (Sederholm, M.: Internl. Collab. Stdy. Grp.: *N Engl J Med* 310:1, 9-15 Jan 5, 1984)

A recent study reports on the efficacy of dipyramidole and aspirin in patients who had had an aorto-coronary-artery bypass graft. A prospective randomized double blind study compared a placebo group with one year use of dipyramidole and aspirin in 407 patients. Distal anastomoses occluded in 22% of 171 treated patients and in 47% of the 172 control cases. The results thus warrant the use of these preparations for at least one year. (Chesebro, J. H. *et al: N Engl J Med* 310:4, 209-14 Jan 26, 1984)

A recent feature suggests that asymptomatic women should have annual physical examinations and mammographies annually or every second year. In 1982 the average fees ranged $70-225, well worth the cost for early detection of breast cancer. Additional guidelines are available in *Ca*, Volume 33, page 255, August 1983. (Dodd, G.D.: *Ca* 34:1, 57-59 Feb 1984)

Skin patches impregnated with clonidine were evaluated in double blind study for treating mild hypertensive patients. In 20 patients with mild hypertension ranging between 91-105mm Hg diastolic pressure, the topical application of these patches at weekly intervals reduced the diastolic pressures to below 90mmHg in 12 patients. Their plasma levels were lower than with oral medication and side effects were less severe. (Weber, M. A. *et al: The Lancet* 8367:1, 9-11 Jan 7, 1984)

A recent study reported that thin and transparent vasa vasorum had been noted in an autopsy. This rarely occurs in normal coronary vessels. Coronary vessels with atherosclerotic involvement showed intimal thickening or frank calcifications with a dense plexus of microvessels suggesting neovascularization. These extended from the adventitia through the media into the thickened intimal layer. This may represent a normal response to injury by the macrophages and the lowered oxygen tensions. (Barger, A. C., *et al: N Engl J Med* 310:3, 175-7 Jan 19, 1984)

Genitourinary symptoms are among the most common causes for visits to physicians by women. Two thirds of 204 women were seen because of GU symptoms and one third were seen for routine examinations. Only 34% of symptomatic women exhibited abnormalities with routine laboratory procedures of urinalysis-chem and microscopic, vaginal pH, saline smear of vaginal discharge, routine urine culture, gonorrheal culture, and 10% potassium hydroxide smears. Selected nonroutine laboratory tests were confirmatory in 66% of the symptomatic patients. In asymptomatic patients 32% had evidence of urinary tract infections by culture, especially yeast. Symptomatic patients therefore should have more than the routine tests performed in physicians' offices. (Berg, A. O. *et al: JAMA* 251:5, 620-5 Feb 3, 1984)

Chlamydia trachomatis was isolated from 9 of 19 patients with acute, nondiarrheal Reiter's syndrome. This infection can trigger the Reiter's syndrome in susceptible men and the exaggerated immune response may play a role in the pathogenesis of this disease. *C. trachomatis* is a significant genital pathogen and effective therapy should thus be given to all patients with this syndrome as well as to their regular sexual partners. (Martin, D. H. *et al: Ann Int Med* 100:2, 207-13 Feb 1984)

Gold therapy was evaluated in 23 patients with rheumatoid arthritis. A complete remission was noted in 48%, a partial response in 9%, and a poor response in 43% at the end of one year of therapy. All 23 cases required a rechallenge with gold after approximately 2.2 years. Only 17% showed a good response with the second course of gold therapy, and all these four patients were previously in remission with the initial course. Dermatitis had occured in 35% of patients with initial course. Retreatment elicited toxic effects in 11 patients, 48% of cases with dermatitis in eight, proteinuria in two, thrombocytopenia, and hepatotoxicity one each. (Evers, A. E., Sundstrom, W. R.: *Arthr Rheum* 26:1071-5 Sept 1983)

Erectile impotence is reported in patients receiving radiation therapy for prostatic cancer. This occured in 15 of 23 patients receiving radiation therapy. Arteriography revealed bilateral occlusive disease in the distal internal pudendal and penile arteries overlying the pelvic radiation field. (Goldstein, I. *et al: JAMA* 251:7,903-10 Feb 17, 1984)

Clinicians are encouraged to evaluate chromosomal abnormalities whether in numbers or in structure. Numerical abnormalities occur during meiotic cell division preceding the formation of the egg or sperm, or in the early stage of mitotic cleavage division. These syndromes are associated with Klinefelter's syndrome (47 XXY), Turner's syndrome (45 X and variants), the XYY state (47 XYY) and the triple X female (47 XXX). Chromosomal abnormalities occur in 1 of 160 newborns and warrant chromosomal studies especially when stillborn and congenital abnormalities appear. Amniocentesis in the middle of the second trimester is safe and reliable. (Hamerton, J. L.: *N Engl J Med* 310:5, 314, Feb 2, 1984)

A prospective randomized study on the effect of smoking of 935 pregnant women showed that birth weight and length of infants were significantly greater in the group encouraged to discontinue smoking when contrasted to the control group that continued smoking during pregnancy. Fetal growth retardation may be overcome by antismoking assistance to pregnant women. (Sexton, M., Hebel, R.: *JAMA* 251:7, 911-5 Feb 17, 1984)

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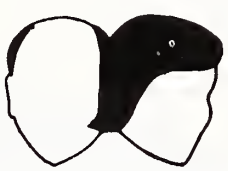
(Continued from page 352)

Answers: 1. B, D, E 2. A, B, D

The ECG shows a normal sinus rhythm with a prolonged PR interval of 0.26 seconds, best seen in leads II and V_1. In addition to this first degree AV block, the QRS is prolonged to 0.14 seconds. The QRS conduction delay is directed anteriorly. This is complete right bundle branch block with a marked rightward QRS axis to 120°. This suggests right bundle branch disease and left posterior hemiblock. With a prolonged PR interval, there may be trifascicular disease. The third fascicle, the anterior division of the left bundle branch, may be the cause of the PR prolongation, not the AV node. A premature ventricular beat is seen in the last column ($V_4V_5V_6$). On telemetry, several premature ventricular beats were recorded. An echocardiogram could evaluate his valvular heart disease as well as his ventricular function. The echocardiogram showed a dilated hypocontractile left ventricle. Early closure of the mitral valve was also seen, compatible with aortic regurgitation. Since the patient had developed congestive heart failure, a cardiac catheterization was performed. This confirmed the presence of severe aortic regurgitation and left ventricular dysfunction. The coronary arteriogram was normal. Conduction system disease was obviously present on the electrocardiogram but no advanced heart block was ever demonstrated. Open heart surgery was performed with an aortic valve replacement. Since no heart block could be demonstrated, no pacemaker was used. However, a myocardial pacemaker lead was sewn on the left ventricle at the time of aortic valve replacement in anticipation of heart block. At two years follow-up, the patient is asymptomatic and the ECG is unchanged. This patient shows that progression of incomplete trifascicular conduction system disease to complete heart block varies widely. There is no indication to use pacemakers prophylactically in these chronic patients unless symptomatic heart block can be demonstrated. ◀

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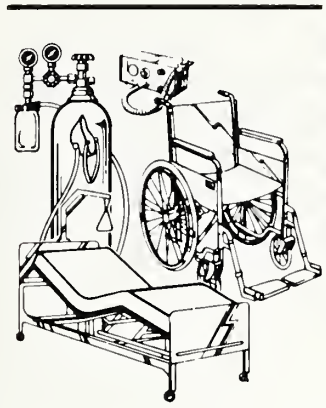
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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JUNE

Gastroenterology
Inflammatory Bowel Disease: Current Concepts in Diagnosis and Management
For: MDs, RNs, LPNs. Symposium, June 1, 8am-5pm, Springfield Hilton. **Sponsor:** Springfield Clinic, 1025 S. Seventh St., Springfield 62708-3746. **Fee:** $25 **Credit:** Category 1, 8 hours. **Contact:** Ernesto B. Eusebio, M.D. **Phone:** 217-525-4524

Stress Management and Relaxation Skills
Teaching Stress Management and Relaxation Skills
For: MDs, RNs, Health Care Prof. Workshop, June 3-8, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AACN 3.5 CEU's

Pain Management
Management of Pain
For: MDs, Office Staff. Symposium, June 6, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed.D. . **Phone:** 217-782-7711

Suicide Intervention
For: Health Professionals. Workshop, June 7, Green Bay, Wisconsin; June 8, Wausau, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $55. **Reg. Limit:** None. **Credit:** Category 1, 6 hours; UW-Extension CEU's, 6. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

OB/GYN and Neonatal/Perinatal
Obstetric and Neonatal Aspects of Infant Respiratory Distress Syndrome
For: MDs, RNs, Resp. Therapists. Conference, Workshops, June 7-8, Madison Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $210 MDs; $140 Other. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; UW-Extension CEU's, 13. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Cardiology
Advanced Cardiovascular Diagnosis and Therapy
For: MDs. Seminar, June 7-9, 8am-5pm, Westin Hotel, Chicago. **Sponsor:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. **Fee:** $295. **Reg. Limit:** 85. **Credit:** Category 1, 18 hours; AAFP Prescribed, 18 hours. **Contact:** Doris Price. **Phone:** 800-525-8651, Ext. 123

Nephrology/Renal
Clinical Approach to Arterial Blood Gases and Electrolytes
For: MDs. Course, June 8-9, Peoria. **Sponsor:** American College of Physicians, Postgraduate Division, 4200 Pine St., Philadelphia, Pennsylvania 19104. **Fee:** $165 ACP Members, FACP, Res., Research Fellows; $240 Non-Members; $130 ACP Assoc. **Reg. Limit:** 200. **Credit:** Category 1, 12 hours. **Contact:** Maxine Topping. **Phone:** 215-243-1200

Orthopedics
Specialty Review in Orthopedics
For: Orthopedic Surgeons. Lecture, June 10-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** TBA. **Credit:** Category 1, 66 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Pathology
Surgical Bleeding Problems: Anticoagulant Monitoring
For: Pathologists, Clinical Chemists. Symposium, June 11, 7pm Drake Hotel, Chicago. **Sponsor:** Chicago Pathological Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** None. **Reg. Limit:** None **Credit:** Category 1, 2 hours. **Contact:** Marshall H. Short, M.D., S.C. **Phone:** 312-626-4300, Ext. 5720

Surgery
Oncology Symposium
For: MDs, RNs. Lecture, June 11, Sangamo Club. **Sponsor:** Springfield Clinic, 1025 S. Seventh St., Springfield 62708-3746. **Fee:** None. **Reg. Limit:** 60. **Credit:** Category 1, 1.5 hours. **Contact:** Ernesto B. Eusebio, M.D. **Phone:** 217-525-4524

Industrial Fitness
For: MDs, RNs, Allied Health Professionals. Workshop, June 11-15, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 450. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

Cardiac Rehabilitation
Cardiac Rehabilitation Workshop
For: MDs, RNs, Allied Health Professionals. Workshop, June 11-15, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed 35 hours, AACN 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

OB/GYN
Fifth Annual Chicago Area Schools of Medicine Review Course in Obstetrics and Gynecology
For: Gynecologists. Course, June 11-16, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago 60637. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, 36 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Internal Medicine
Innovations in Subspecialty Care
For: MDs. Symposium, June 14-15, Jumer's Lodge, Urbana. **Sponsor:** Carle Foundation Hospital, Department of Medical Education, 611 W. Park St., Urbana 61801. **Fee:** $75. **Reg. Limit:** TBA. **Credit:** Category 1, 10 hours; AAFP Elective, 10 hours. **Contact:** Deborah C. Rugg. **Phone:** 217-337-3022

Weight Control
Weight Control Workshop
For: MDs, RNs, Allied Health Professionals. Workshop, June 18-22, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed 35 hours; AACN, 3.5 CEU's

Gynecologic Oncology
Specialty Care in the Primary Setting: Ovarian Cancer
For: MDs. Symposium, June 22-23, Monticello. **Sponsor:** Carle Foundation Hospital, Department of Medical Education, 611 W. Park St., Urbana 61801. **Fee:** $50. **Reg. Limit:** TBA. **Credit:** Category 1, 5 hours; AAFP Elective, 5 hours. **Contact:** Deborah C. Rugg. **Phone:** 217-337-3022

Medicine and Pathology
Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, June 26, 4:30-6:30pm. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Pediatrics
Specialty Review in Pediatric Hematology/Oncology
For: Pediatric Hematologists & Oncologists. **Lecture:** June 27-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $310. **Reg. Limit:** 90. **Credit:** Category 1, 24 hours. **Contact:** Robert J. Baker M.D. **Phone:** 312-633-2600

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JULY

Family Medicine

Symposium on Computers
For: MDs, RNs, LPNs. Symposium, July 2, 6:30pm, Sangamo Club. **Sponsor:** Springfield Clinic, 1025 S. Seventh St. Springfield 62708-3746. **Fee:** None. **Reg. Limit:** 60. **Credit:** Category 1, 1.5 hours. **Contact:** Ernesto B. Eusebio, M.D. **Phone:** 217-525-4524

Clinical Medicine Update
For: GPs, FPs. Lecture, July 23-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390. **Reg. Limit:** 90. **Credit:** Category 1, 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Risk Factor Management

For: MDs, RNs, Allied Health Professionals. Workshop, July 9-13, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

Cardiac Rehabilitation

For: MDs, RNs, Allied Health Professionals. **Workshop:** July 9-13, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

OB/GYN

Gynecologic and Obstetric Surgery
For: Obstetricians and Gynecologists. Course, July 12-14, Rosemont. **Sponsor:** American College of Obstetricians and Gynecologists, 600 Maryland Ave., S.W., Washington, DC 20024. **Fee:** $315 ACOG Fellows & Jr. Fellows; $158 Jr. Fellow Residents, Life Fellows; $365 Others. **Reg. Limit:** TBA. **Credit:** Category 1, 16 hours; 16 cognates of ACOG. **Contact:** Patience A. Schenck. **Phone:** 202-638-5577

Weight Control

Weight Control Workshop
For: MDs, RNs, Allied Health Professionals. Workshop, July 16-20, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's.

Emergency Medicine

Fourth Annual Common Emergency Care Problems
For: MDs, RNs, Allied Health Professionals. Conference, Workshops, July 19-20, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1 TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Specialty Review in Emergency Medicine
For: MDs. Lecture, July 30-August 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480. **Reg. Limit:** TBA. **Credit:** Category 1, 45 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Pediatrics

Specialty Review in Pediatrics
For: Pediatricians. Lecture, July 23-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** TBA. **Credit:** Category 1, 65 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, July 31, 6:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

AUGUST

Surgery

Soft Tissue Surgery Workshop
For: MDs. Workshop, August 4-5, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $290. **Reg. Limit:** 60. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Specialty Review in General Surgery, Part II
For: Surgeons. Lecture, August 20-31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Reg. Limit:** TBA. **Credit:** Category 1, 100 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Fiberoptic Colonoscopy
For: MDs. Lecture, August 22-24, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Fiberoptic Esophagogastric Endoscopy
For: MDs. Lecture, August 27-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Sports Medicine

Seventh Annual Sports Medicine Symposium
For: MDs, Sports Professionals. Symposium, Workshop. August 3-4, Waunakee, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AOA, TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Urology, Radiology

Endourology and Ureteroscopy: Triumphs and Pitfalls
For: Urologists, Radiologists. Lecture, August 3-4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 90. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Radiology

Sixth Annual Cape Cod Summer Symposium on Ultrasound, CT, and MR
For: Radiologists, Technicians. Symposium, August 6-8, Hyannis, Massachusetts. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $250 MDs; $175 Res., Tech. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; UW-Extension CEU's, 13. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Internal Medicine

Specialty Review in Internal Medicine/Certifying
For: MDs. Lecture, August 5-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** TBA. **Credit:** Category 1, 72 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Clinical Medicine

National Symposium on Sexually Transmitted Disease
For: MDs. Symposium, August 10-12, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** Skokie Valley Hospital/Foundation, Program Office, 9600 Gross Point Rd., Skokie 60076. **Fee:** $295. **Reg. Limit:** 400. **Credit:** Category 1, 15 hours; AAFP Prescribed, 15 hours. **Contact:** Craig Olesen. **Phone:** 312-677-9600, Ext. 3354

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, August 28, 4:30-6:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

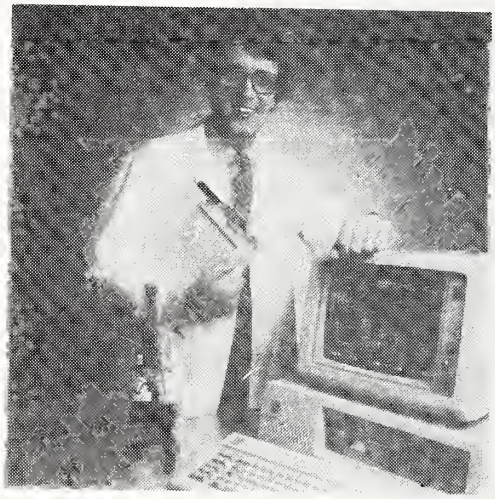
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1. Stone PH, Turi ZG, Muller JE: Efficacy of nitedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PRDCARDIA* (nitedipine) **CAPSULES** For Oral Use

INOICATIONS ANO USAGE: I. Vasospastic Angina: PRDCARDIA (nitedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PRDCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PRDCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose tentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PRDCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PRDCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Pfizer LABORATORIES DIVISION
PFIZER INC

The End of the Beginning



This is not the first and, I assure you, it will not be the last article that I write on malpractice and the professional liability problem. Having gone from the "crisis of availability" in 1975 to the present "crisis of affordability" of malpractice insurance, we have returned to the Illinois General Assembly for legislative help. We have been successful in launching our professional liability reform package. It is unfortunate that the legislature failed fully to consider it this session, but we knew it would be unrealistic to expect quick action on such a complex issue. There can be no doubt, however, that our senators and representatives are aware that this issue will not resolve itself and must receive a high priority for action in next spring's session.

The ISMS legislative package has been referred to subcommittees of House and Senate Judiciary Committees, ostensibly for their study prior to the 1985 legislative session. Trial attorneys anxious to preserve the status quo have bitterly opposed the ISMS legislation, first by attempting to confuse the issue by attacking underwriting practices of professional liability insurers, particularly our Illinois State Medical Inter-Insurance Exchange, and then by accusing physicians of seeking special privileges under the law.

With our legislative efforts stymied, ISMS now plans to turn its attention to a public education program to enlist the public support that we will need to convince the legislature to approve our package during its next session. Your involvement in this is also a high priority item.

This public education process already has begun. In May, ISMS Board of Trustees Chairman Dr. Alfred J. Clementi and ISMIE Investment Committee Chairman Dr. Allan L. Goslin squared off with trial lawyer representatives in a public debate organized by representatives of the Illinois news media. The debate in Streator was the forerunner of what we hope will be many public appearances in the months ahead. The prestigious *Chicago Daily Law Bulletin* reported that the audience sided with us.

We welcome any opportunity to discuss or debate our proposals in a public forum. The medical liability problem has broad societal implications, and we look forward to input from those interested in resolving this complex issue.

A look at recent press coverage indicates that the media perceive that the present medical liability situation in Illinois is just an interprofessional squabble between physicians and attorneys. We must work very hard to convince the media, the general public and the legislature that the problem is much greater than that: it is a societal problem and has adverse effects on the health care of the general public.

Our success in this area depends upon you, the individual physician. Please take the time to talk to your patients about the liability situation to enlist their support. Try to arrange meetings of your local community groups to examine the medical liability problem. Contact representatives of your local news media, and offer your assistance and that of ISMS in developing articles.

We must all communicate with our representatives and senators. Arrange meetings between local legislators and your hospital medical staff, county medical society and/or specialty society. If you need help in identifying or contacting your elected representatives, the ISMS Governmental Affairs staff is available to assist you.

We must not be discouraged by the slowness of the legislative process in Springfield. When we look back a year from now, we will realize that the end of the 1984 General Assembly session was only the beginning of a successful drive for total reform of the medical liability problem.

We have not yet begun to fight. ◀

Robert C. Hamilton, M.D.
President

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Ayerst

Just once each day for initial therapy in hypertension.

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis; erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

ABSTRACTS OF ACTIONS

April 5-8, 1984

Chicago Marriott Hotel
Chicago, Illinois

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

PROFESSIONAL LIABILITY INITIATIVE

Ongoing activity is occurring in the implementation of the Professional Liability Initiative. Market Opinion Research has been involved in developing a public opinion survey. The scope, content and timetable for the survey are being finalized. A tentative draft of the survey questionnaire will be reviewed in May and the survey will be conducted and completed in June.

Specifications for a public relations firm have been developed and candidates to accomplish this are being considered. This public relations firm will develop a plan of action with major themes, organize materials, plan the distribution of materials, and will implement a public relations activity to heighten public awareness of the problem and build support for professional liability reforms.

The Board authorized development of a legislative package and it was introduced this spring. It is possible that the General Assembly will not give serious consideration to the package this session due to budgetary and election issues. Specifically, elimination of the surtax extension will make the budget the major issue, and the entire House and half the Senate are up for re-election. Thus, the legislative package portion of the Initiative is planned to build momentum for an all-out effort in early 1985. Intense activity will be accomplished during the next year to generate support for successful passage of this remedial legislation.

HOSPITAL COST CONTAINMENT BILL (SB 495)

The introduction of Senate Bill 495 last year touched off a debate within Illinois over how to control the rising cost of medical care. The Ad Hoc Committee on SB 495 has met on a continuing basis and developed an alternative to SB 495. This plan is unique in that, unlike all other proposals which included all payors, the ISMS plan provided for hospitals to contract for Public Aid only. The plan has no direct effect on the private sector. The Board approved draft language for an act relating to contracting for hospital health care services by the Illinois Department of Public Aid to hold down Medicaid costs while fostering competition within the Illinois hospital industry.

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

The Council on Economics recommended that ISMS develop an educational brochure and present seminars on PPOs. The purpose of this effort is to alert the membership to the legal and contractual questions raised by this payment methodology. The Board approved publishing of a brochure on PPOs for distribution to the entire membership and a presentation of two seminars on the subject, one in Chicago and one in Springfield.

(Continued on page 432)



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) *LONG ACTING CAPSULES*



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

On Continuing Vigilance

Throughout the year, physicians in their offices or emergency rooms are constantly treating and caring for patients with open wounds incurred at home, at work, or in transit. A large number of patients never seek medical assistance for such injuries. As medical students, interns, and residents we were taught the principles of wound care: when to close, debridement, removal of foreign bodies, antibiotics, tetanus toxoid, etc. While treating a large number of patients with these problems in Alaska, we felt minimal additional precautions were necessary for good treatment. Soap and water cleansing and suture or butterfly repair without gloves were frequently utilized. Upon returning to Illinois, we noted that many nurses insisted upon gowns, gloves, and masks for such treatment programs. Many physicians may feel that this is excessive and not an enhancement of quality of care. Despite this, we still see such routines performed with groundless or factless comments as to the reason (for example, a laceration received in a bicycle fall on a dirt road).

This month's article by Dr. Ruthman, *et. al.,* touches on this subject. With little concern as to the etiology of the wound, (except for specified exclusions), the authors report on the infection rate they noted when comparing mask and cap repair to no cap/mask during treatment. As might be expected, the overall infection rate was low and the wearing of a cap and mask had no relevance.

This article has limitations but the principle idea is worth reviewing and presenting, not only with respect to infection but to many other areas of routine in patient care. We should continue to review and scrutinize policies and programs for their relevance, significance, and value to the patient and quality of care. ◀

Raymond A. Dieter, Jr. M.D.
IMJ Editorial Board

When *you're* sued for malpractice, who will your insurance company be looking out for?

If you're sued for malpractice, the Exchange will supply an attorney who is highly skilled in defense of malpractice claims and who works with the understanding that he represents your interests exclusively.

Attorneys selected by the Exchange to defend claims all understand our aggressive defense philosophy. Furthermore, they're *not* imported from other areas. They know your local court system and how to work within it.

The Exchange also remains committed to fighting non-meritorious claims against its policyholders at all costs. We simply will not settle frivolous claims. And, unlike some other carriers, we cannot and will not settle any claim without your participation in the decision.

Since the Exchange is owned and controlled by physicians, we understand what being the subject of a malpractice suit can mean to a doctor. That's why aggressive defense of our policyholders' interests is the cornerstone of the Exchange's professional liability program.



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Physician Ownership Makes A Difference!

Getting Our Money's Worth

Dear Editor:

The ten o'clock morning coffee roundtable has never been constrained in the scope or depth of its discussion and criticism. It is almost completely indiscriminate, being willing to take on any individual issue or problem. The only constraining factor is that the individual discussed or criticized is never one of those at the table. This alone is sufficient to keep the attendance constant. I recall one instance when our insurance agent was about to complete the writing of a very fine policy when he realized it was approaching ten. He excused himself, left the bottom line unsigned, clients at his desk, and rushed over to be present.

In most groups folks are afraid that if they are absent they will be appointed to a committee or elected to office. With the ten o'clock morning coffee roundtable the concern is that the absent one may be the point of discussion, either personally or as a representative of their profession or occupation. I am certain that our representative in the General Assembly, if he knew the direction and intensity of the discussion, would drop all things legislative and make the ten o'clock event a high-priority item, for surely the legislative activities are most frequently on the pan. Education gets its fair share of shots as well, as do big business, high-paid executives and bureaucrats of all colors.

As I have listened to the discussion and on occasion contributed to it, I have been impressed with the fact that the areas under attack are those for which our folks have the least respect.

Now the one major exception to that rule may be old Doc Frank. He attends when he can; but, if someone has their jeans down expecting a shot of whatever, you can bet that he isn't going to leave them undraped with the needle at the ready but on the table just to make the ten o'clock coffee roundtable. Doc takes care of his business and our health care needs first; and, if there is time left over, he will enjoy our company.

On occasion the health care system comes under attack—never old Doc or the hospital down the road. The attacks are on the cost of health care, not the quality and not the people devoting their time and talents to health care. Clearly our pocketbooks are hurting. The emotional and intellectual dichotomy that we all suffer is how to maintain that quality but not spend as much money getting it as we seem to be doing.

This question of how much we are spending came up; and, being a reader of things medical, I got in my bit of erudition by quoting that health care costs were about 10% of the gross national product. Whereupon I had to explain what the GNP was—a concept a little hard to grasp here in Mt. Hawley. When the concept was accepted, the discussion took a wry turn. Old Asa asked why that was too much. "Surely more than 10% of the GNP is spent on the military. Wasn't our nation's health," queried Asa, "worth as much as our military strength and presence?" No one debated that on the other side. Although all agreed that health care costs were getting noticeable, we also wondered if that wasn't a darned good place to put that 10%.

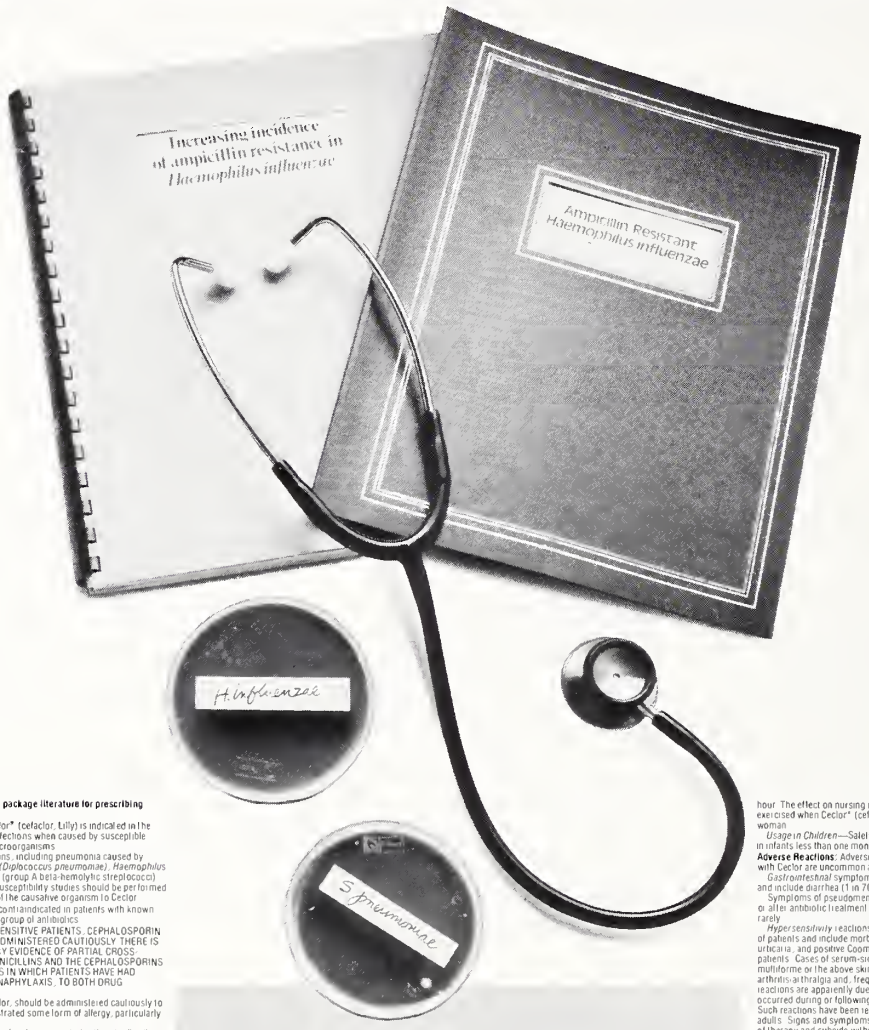
Education and the cost of education is frequently a subject of debate. However, there the opinion is that more money could be spent there as well as on health care if we could be sure that the quality of the education was good and kept up with the cost. It was interesting to note that in the discussion on health care there were no expressed or inferred qualms about the quality of the care. If that much money is spent, we are sure that we are getting our money's worth and perhaps it should be spent. On the other hand, spending more money on education or on legislation or on new regulation raises the doubt in the minds of the roundtable as to the basic need and quality that will be achieved for that additional expense.

The coffee roundtable always dissolves by mutual agreement. Everyone leaves at the same time—a truly self-defense measure. Almost always Asa has the last word as he screws on his straw hat. "With people like Doc doing the delivering, I am not concerned about how much we pay into it. We're surely going to get our money's worth." ◀



Sincerely,
Emerson Goodwins

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip; USP; Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis-arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*: 91, 1975.
2. Antimicrob. Agents Chemother., *11*: 470, 1977.
3. Antimicrob. Agents Chemother., *13*: 584, 1978.
4. Antimicrob. Agents Chemother., *12*: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy). II:880. Washington, D.C.: American Society for Microbiology; 1978.
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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons; 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035

Triplicate Prescription Requirements Changed

The Illinois Dangerous Drugs Commission (IDDC) has advised that, effective July 1, 1984, they will consolidate with the Department of Mental Health and Developmental Disabilities' Division of Alcoholism to become the Illinois Department of Alcoholism and Substance Abuse (IDASA). The new agency will accept operational responsibility for the State's triplicate prescription control program from the Illinois Department of Registration and Education (IDRE). This consolidation will cause several changes in program operations.

The address to which physicians, dentists, podiatrists, and veterinarians send applications for triplicate prescription blanks will change, as will the address to which pharmacies submit the processed State copy of the triplicate prescription form. The new address will be: Illinois Department of Alcoholism and Substance Abuse, Triplicate Prescription Control Section, 100 East Washington Street, Springfield, Illinois 62706.

IDASA will continue to operate IDRE's existing triplicate prescription program for approximately six months until a redesigned system becomes operational on or about January 1, 1985. The fee for 100 triplicate blanks will remain at $5.00 until the new system begins operations. In September of 1984, instructional materials will be issued to all medical professionals in the State regarding any procedural changes caused by the implementation of the new system. Further information about the triplicate prescription control program may be obtained by calling: IDASA-Chicago—(312)822-9860 and IDASA-Springfield—(217)782-0685. ◀



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Obituaries

***Baquero, Alfonso,** Danville, died April 11, 1984, at the age of 66. Dr. Baquero was a 1949 graduate of the University of Geneva Medical School, Switzerland.

Beamer, Parker R., Oak Park, died March 8, 1984, at the age of 69. Dr. Beamer was a graduate of the Chicago Medical School.

****Boshes, Benjamin,** Chicago, died in April, 1984, at the age of 77. Dr. Boshes was a 1931 graduate of the Northwestern University Medical School, Chicago.

***Budrys, Stanley,** Longboat Key, Florida, died April 10, 1984, at the age of 67. Dr. Budrys was a 1941 graduate of Vytauta Didziojo Universiteto Medicinos Fakelteto, Kaunas, Lithuania.

***Elliott, Harold E.,** Harrisburg, died May 5, 1984, at the age of 52. Dr. Elliott was a 1956 graduate of the University of Illinois College of Medicine, Chicago.

****Ellis, Robert B.,** Fresno, California, died April 5, 1984, at the age of 85. Dr. Ellis was a 1926 graduate of the St. Louis University School of Medicine, St. Louis.

****Finkel, Morris D.,** Sherman Oaks, California, died April 16, 1984, at the age of 77. Dr. Finkel was a 1932 graduate of Rush Medical College, Chicago.

***Graham, James Francis,** Evergreen Park, died April 18, 1984, at the age of 61. Dr. Graham was a 1946 graduate of the Loyola University Stritch School of Medicine, Maywood.

Hodges, Hazel, Mundelein, died April 9, 1984, at the age of 93. Dr. Hodges was a 1920 graduate of the Indiana University School of Medicine, Indianapolis.

Hoff, S. Dayton, Willowbrook, died February 19, 1984, at the age of 85. Dr. Hoff was a graduate of the Chicago Medical School.

Lerner, Hedi R., Skokie, died March 22, 1984, at the age of 57.

****Loverde, Albert A.,** Chicago, died March 29, 1984, at the age of 77. Dr. Loverde was a 1933 graduate of the Washington University School of Medicine, St Louis.

McKeon, John C., Glenview, died February 9, 1984, at the age of 65. Dr. McKeon was a 1957 graduate of the Loyola University Stritch School of Medicine.

***Messiha, Nabil,** Mount Vernon, died April 5, 1984, at the age of 50. Dr. Messiha was a 1959 graduate of Kas-el Aini-Faculty Medicine Cairo University, Cairo.

***Miller, Watson,** Herrin, died May 1, 1984, at the age of 71. Dr. Miller was a 1942 graduate of Northwestern University Medical School, Chicago.

***Protich, Bosko,** Joliet, died March 30, 1984, at the age of 68. Dr. Protich was a 1940 graduate of the University of Zagreb, Yugoslavia.

***Rhoades, Robert G.,** Pekin, died April 21, 1984, at the age of 58. Dr. Rhoades was a 1949 graduate of Tufts Medical School, Massachusetts.

Schmehil, Edward J., Roselle, died February 18, 1984, at the age of 71.

****Solomon, Alfred P.,** died April 8, 1984, at the age of 86. Dr. Solomon was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

****Wright, Katharine,** Evanston, died April 3, 1984, at the age of 91. Dr. Wright was a 1918 graduate of the George Washington University School of Medicine, Washington D.C.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Correction: The April obituaries included notice of the death of Dr. Matas Mickus of Medinah, and listed the school of graduation as the First Moscow Order-of-Lenin Medical Institute, Moscow. Dr. Mickus matriculated in 1916 from the Vytauta Didziojo Universiteto Medicinos Fakelteto, Kaunas, Lithuania.

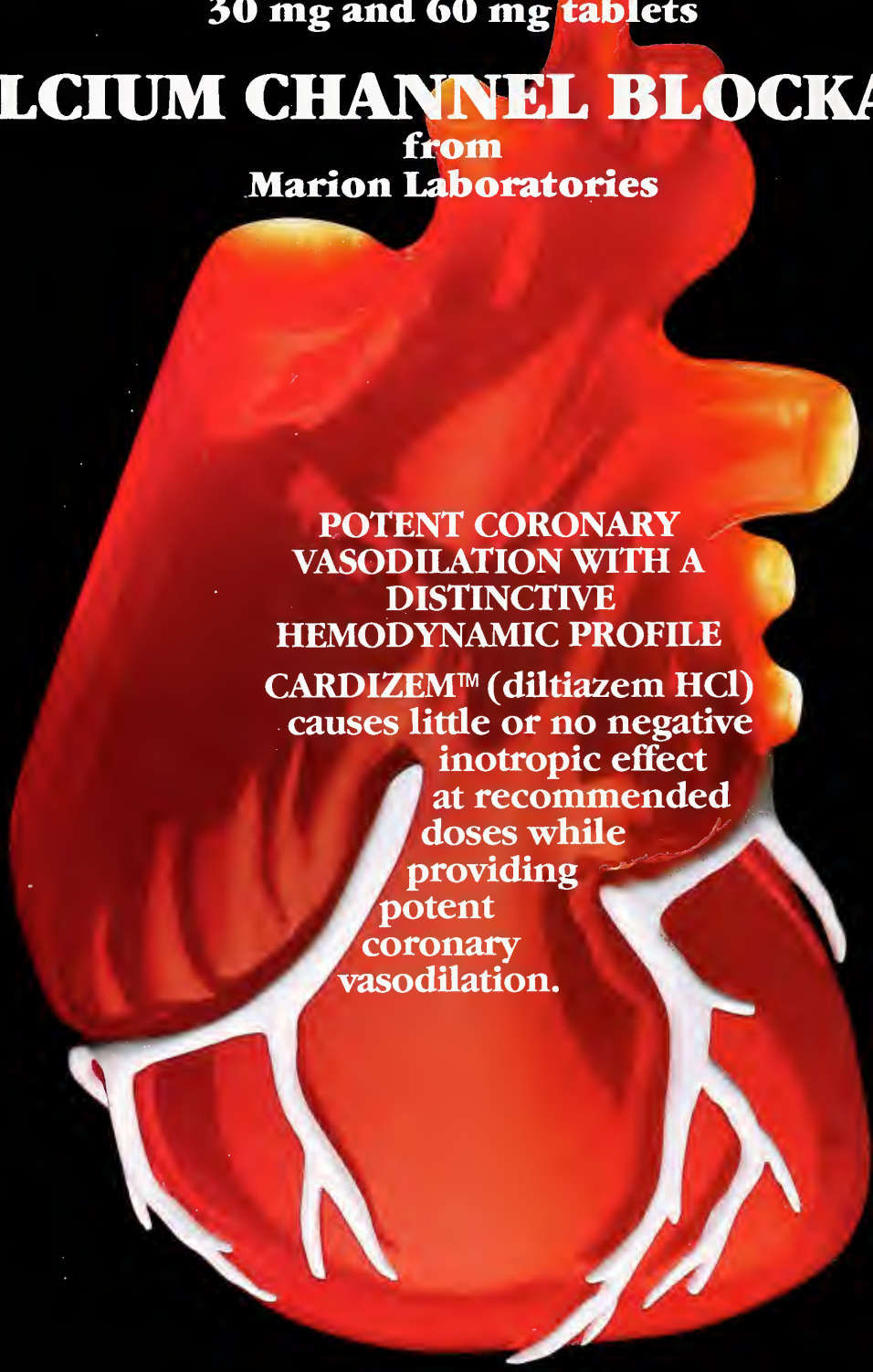
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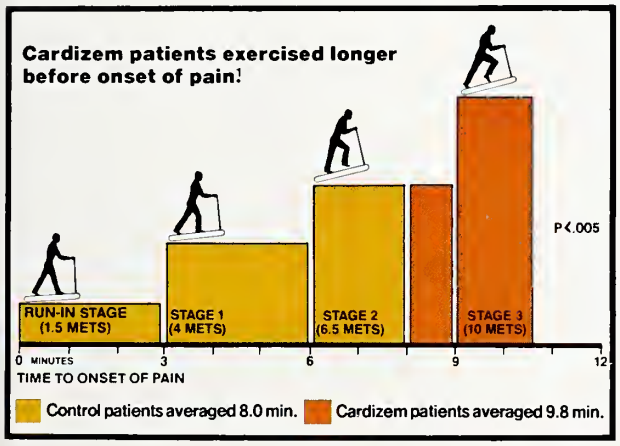
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Calcium channel blockade with CARDIZEM™ (diltiazem HCl) produces changes in cardiovascular hemodynamics and coronary blood flow that are of benefit in myocardial ischemia.

CARDIZEM™ (diltiazem HCl) ALLOWS PATIENTS TO SIGNIFICANTLY PROLONG EXERCISE TOLERANCE, EVEN IN DEMANDING BRUCE PROTOCOL EXERCISE TESTS[1] (n = 15)†



This study is of special significance because patients not only exercised longer but *to the next higher stage* in the Bruce protocol.

A Bruce protocol with a run-in stage was used for all tests. Each stage lasts three minutes.

In other studies, Cardizem produced 41% to 68% reduction of Prinzmetal's variant angina attacks[2]

†This study is a report from one center in a multicenter study.

Therapy with Cardizem produced a low incidence of side effects.

In placebo-controlled trials (222 patients) conducted in the United States, the incidence of adverse reactions reported during Cardizem therapy was not greater than that reported during placebo therapy.

Those adverse reactions reported most frequently with Cardizem in 959 patients in controlled and uncontrolled U.S. trials have been:

- Nausea 2.7%
- Swelling/edema 2.4%
- Arrhythmia 2.0%
- Headache 2.0%
- Rash 1.8%
- Fatigue 1.1%

Other reactions reported infrequently (less than 1%) are listed in full prescribing information on adjacent page.

Please see adjacent page for full prescribing information.

References:
1. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. *Chest* 78 (July suppl): 234-238, 1980.
2. Schroeder JS, Feldman RL, Giles TD, et al: Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 72:227-232, 1982.

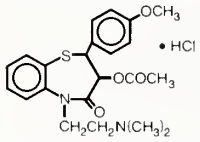
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PROFESSIONAL USE INFORMATION

cardizem™
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM™ (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate/blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent as a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents. CARDIZEM has been effective in short-term controlled trials in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness is incomplete.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (four of 959 patients for 0.42%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** There has been a single report in a patient receiving 120 mg of diltiazem tid of marked transaminase elevation (SGOT 4500, SGPT 2300) accompanied by hyperbilirubinemia (to 3 mg%), occurring after four days of treatment. The enzyme abnormalities resolved entirely, and enzymes were nearly normal a week after cessation of treatment. No rechallenge was carried out, but the patient had no evidence of viral hepatitis and received no other drugs but isosorbide dinitrate.

 No other similar liver injury has been reported in clinical trials, but marketing experience in Europe has resulted in a rechallenge-confirmed instance of hepatocellular injury. However, it should be noted that there have been further episodes of raised transaminases in the absence of diltiazem in this patient, so that the relationship to diltiazem of the abnormalities is not completely clear. Other instances of transaminase elevation have been reported in Europe, but their relationship to the drug is uncertain.

PRECAUTIONS

General. CARDIZEM is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities; the effect of diltiazem on serum digoxin levels has not been examined. The safety of the combination of CARDIZEM and beta-blockers or digitalis is currently being investigated in well-controlled studies.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded. Experience with an added beta-blocker is also extremely limited.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

In addition, the following have been reported infrequently and represent occurrences which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are nausea (2.7%), swelling/edema (2.4%), arrhythmia (2.0%), headache (2.0%), rash (1.8%), and fatigue (1.1%). In addition, the following events were reported infrequently (<1.0%). The order of presentation corresponds to the relative frequency of occurrence.

Cardiovascular:	Flushing, congestive heart failure, bradycardia, hypotension, syncope, pounding heart.
Central Nervous System:	Drowsiness, dizziness, lightheadedness, nervousness, depression, weakness, insomnia, confusion, hallucinations.
Gastrointestinal:	Vomiting, diarrhea, gastric upset, constipation, indigestion, pyrosis.
Dermatologic:	Pruritus, petechiae, urticaria.
Other:	Photosensitivity, nocturia, thirst, paresthesias, polyuria, osteoarticular pain.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

Experience in 959 patients taking oral doses of CARDIZEM resulted in three cases (0.31%) of second-degree AV block and one case (0.10%) of third-degree AV block at doses of 240 to 360 mg daily.

In rare instances, mild to moderate transient elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK have been noted during CARDIZEM therapy. A single incident of markedly elevated liver enzymes associated with symptoms was reported in a patient taking 360 mg per day for four days. Drug was discontinued and enzymes normalized within 1 week.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experiences with oral diltiazem have not been reported. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually to 240 mg (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. The effectiveness and safety of dosages exceeding 240 mg per day are currently being investigated. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents.

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 00188-1771-47). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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From the Department of Public Health

Statewide Health Interview Survey

The Department conducted a statewide survey of more than 2000 residents for a report on health risks, how people view the status of their health and how they use health services. Highlights of the survey, available from IDPH(217-785-2060), were as follows (1982 data):

- 93% of persons reporting no physician visits in the past year and 90% of those reporting 1-2 visits, stated that their health was good or very good. However, of those reporting three or more visits to a physician's office in the past year, only 63% reported having good or very good health.
- Of those who felt they could control their health, 61% thought their health was good or very good. Of those who felt they could not control their health, 83% thought their health was good or very good.
- The majority (56.3%) of those interviewed received their usual medical care at a physician's office. Slightly over half (50.2%) reported a one-way travel time for medical care of 20 minutes or less.
- About ⅓ of the respondents had direct experience with emergency medical services in the past year. A total of 51% of these received emergency care within 20 minutes, while 15% waited over an hour. Actual time to receive emergency medical service was notably longer than the public's estimation.
- Slightly more than 25% of the respondents had a household member in a hospital overnight during the past year. Only 6% reported that a relative had been admitted to a nursing home in the past year.
- 31.1% of the men interviewed and 28.8% of the women smoked at least 10 cigarettes a day.
- 73% of the men interviewed and 84% of the women had had their blood pressure checked in the past year. High blood pressure was first diagnosed most often in a physician's office. Of those who were prescribed medication for hypertension, only 5.6% reported that they were not taking the medication. Among non-hypertensives, only 6.2% were aware that high blood pressure may be asymptomatic.
- 73.6% reported exercising or improving their physical fitness in the past month. 64.5% of all men and 73.5% of all women indicated they engaged in moderate to heavy physical effort in daily activities.
- Alcohol was specified as a means of relieving tension by 4.7% of the sample. 79% of those had five or more drinks on occasion. Among those not indicating alcohol as a means for tension relief, 32% had five or more drinks on occasion.
- 43% stated that they do nothing for stress.
- Among people who reported themselves to be obese, only 25% perceive obesity as a factor causing heart attacks and only 14% believe that diet is a factor in heart attacks.
- Tension, stress or anxiety was the most common perceived cause of heart attack. This was followed by obesity, smoking, lack of exercise, overexertion and diet.
- Of the causes for cancer, smoking was the most often named risk factor, followed by specific foods and additives, heredity or body deficiency, poor eating habits and environmental pollution.
- Magazines and newspapers were the most mentioned sources of health information, with physicians named third. However, those with higher incomes listed the physician as first.
- Only 5.9% reported having no health insurance.

(Source: Survey Stats-Statewide Health Interview Survey, 1982, IDPH)

DOCTOR'S NEWS

LICENSE RENEWAL REMINDER

All Illinois medical licenses will be subject to renewal by the Illinois Department of Registration and Education as of July 31, 1984. Forms for license renewal are to be mailed to physicians by the Department.

The Department mails the renewal form to the "address of record," that is, that address listed by the physician at the time of 1982 license renewal. Physicians whose mailing addresses have changed in the interim are obliged to advise the Department.

At press time, SB1657 had passed both Houses of the Illinois General Assembly and the Governor was expected to sign it into law. This bill, and the rules to be implemented pursuant to its signing, are expected to cause several changes in medical license renewal procedures.

It is expected that the following changes will be implemented: licenses will be renewed every three years, rather than every two years. The renewal fee will increase from $20 to $35 annually, for a total of $105 for three years. Controlled substance registration will be billed concurrently, rather than separately. The $5 per office/per year fee (totalling $15) for controlled substance registration will not increase. Contingent upon the Governor's signature, these changes will be reflected in 1984 license renewal notices from the Department.

Failure to renew on time results in a late fee penalty and also could jeopardize liability insurance coverage. Further information may be obtained from the Medical Licensure Section, Department of Registration and Education, 320 W. Washington St., Springfield IL 62786; (217-785-0800).

TRIPLICATE PRESCRIPTION PROGRAM CHANGES

A number of changes in the State of Illinois triplicate prescription program have been announced. Changes which will directly impact physicians are detailed on page 385.

PHYSICIANS IN THE NEWS

Ann M. Lawrence, M.D., Ph.D., Hinsdale, professor of medicine and biochemistry at Loyola University's Stritch School of Medicine, has been appointed to a four year term on the National Advisory Research Resources Council of the National Institutes of Health.

The following physicians have been elected to fellowship in the American College of Physicians: **Donald W. Aaronson, M.D.,** Des Plaines; **Edward R. Garrity Jr., M.D.,** Evergreen Park; **Ghazi Jawad, M.D.,** Oak Park; **Toh-Hoai Lim, M.D.,** Northbrook and **John W. Matseshe, M.D.,** Libertyville. Chicago physicians **Daniel C. Batlle, M.D., Marilyn D. Ezri, M.D., Shirley A. Roy, M.D., Mark Siegler, M.D., Frank R. Venezio, M.D.,** and **Peter M. Wolkonsky, M.D.** were also named fellows.

The Illinois Academy of Family Physicians has nominated **Lawrence L. Hirsch, M.D.,** Chicago, for the office of vice speaker, American Academy of Family Physicians. Dr. Hirsch, an ISMS trustee from the third district, is professor and chairman, department of family medicine, Chicago Medical School.

Aldo F. Pedroso, M.D., Chicago, recently received a certificate of merit in recognition of five years' outstanding community service to the village of Skokie.

Leo M. Henikoff, M.D., dean and vice president of medical affairs, Temple University School of Medicine, has been elected trustee and president of Rush-Presbyterian-St. Luke's Medical Center. Dr. Henikoff, who will also serve as professor of medicine, Rush Medical College and senior attending, Presbyterian-St. Luke's Hospital, will take office July 1.

Roy Patterson, M.D., F.A.C.P., Chicago, was named a Master of the American College of Physicians, an honor reserved for fellows of the College who have maintained the highest standards of clinical performance and medical scholarship. Only 150 of the 60,000 ACP members hold the rank of Master.

James W. West, M.D., has been named medical director of the Betty Ford Center at Eisenhower, Rancho Mirage, California. The Betty Ford Center is a well known chemical dependency recovery hospital. Dr. West, a psychiatrist and surgeon formerly affiliated with Little Company of Mary Hospital, Evergreen Park and Rush Medical College, was the founding chairman of the ISMS Panel for the Impaired Physician.

George F. Smith, M.D., Chicago, received the Outstanding Service Award from the National Association for Down's Syndrome during their recent national meeting. Dr. Smith, who published pertinent research in the August, 1983, issue of *IMJ* (164:2, 101-104) is chairman of the department of pediatrics at Illinois Masonic Medical Center.

Frank Hussey, Jr., M.D., Wilmette, has been named a chancellor of the American College of Radiology. A fellow of the College, Dr. Hussey is a clinical professor at the University of Illinois College of Medicine, Chicago.

Philip Thorek, M.D., Chicago, has been named 1983 speaker of the year by the Journal of Continuing Medical Education for Primary Physicians. Dr. Thorek, a talented humorist, served as keynote speaker at the 1981 meeting of the ISMS Fifty Year Club.

Harold A. Shafter, M.D., Chicago, has been elected a member of the American College of Physician Executives. Dr. Shafter, executive vice president for medical and professional affairs, Lutheran General Hospital, is a professor of clinical medicine, UI College of Medicine, Chicago.

DRUNK DRIVING

The National Safety Council has developed a phamplet about the dangers of drinking and driving. "Will

You Make It Home Tonight?" may be obtained at no cost from the Public Relations Department, National Safety Council, 444 N. Michigan Ave., Chicago, IL 60611. A self-addressed stamped business sized envelope should be enclosed with the request. Quantity purchases are available.

CMS PRESENTS PUBLIC SERVICE AWARD

Louis P. River, M.D., Oak Park, was presented with the Chicago Medical Society's seventh annual public service award during the Midwest Clinical Conference, March 23. Presenting the award, Chicago Medical Society President Harry A. Springer, M.D., cited Dr. River's 60 years of dedicated service to the medical profession and continued involvement with the Illinois Surgical Society and U.S. Section of the International College of Surgeons.

AUXILIARY SCHOLARSHIPS

The Chicago Medical Society Auxiliary is offering three $500 scholarships for Cook County residents under the age of 30 who are enrolled or plan to enroll in an accredited Cook County school offering degrees in allied health sciences. (Pre-med and medical students are not eligible.) Interested parties should send an introductory letter outlining educational interests and financial need to Chicago Medical Society Auxiliary, Attn.: Scholarship, 515 N. Dearborn, Chicago, IL 60611.

TWO ANNUAL PRIZE OFFERS

The Institute of Medicine of Chicago is accepting papers for consideration in two annual research competitions. The Dr. and Mrs. Elven J. Berkheiser Prize for research in orthopaedic surgery offers an award of $750 for the best thesis for original research work in the field of orthopaedic surgery completed in 1984. The investigation may be in the fundamental sciences, provided that the work has a definite bearing on orthopaedic conditions.

The John L. And Beatrice S. Keeshin Prize awards $1,000 for the best thesis for original research in the field of Alzheimer's Disease or glaucoma completed in 1984.

In each case, the greater part of the work must have been completed in a metropolitan Chicago institution. Papers may not have been published prior to submission. Competition for 1984 is open to physicians who received their M.D. degree six years or less prior to July 2, 1984 excluding terms of active duty in the armed forces.

Manuscripts are to be submitted in quadruplicate with a resume (S.S.# requested) to the secretary of the Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago, Illinois, 60604 no later than November 15, 1984.

FETAL ALCOHOL SYNDROME MATERIALS

The National Institute on Alcohol Abuse and Alcoholism has announced availability of educational materials for physicians, medical educators and patients on the Fetal Alcohol Syndrome (FAS). Other alcohol abuse education materials are also available. Further information may be obtained by writing the National Clearinghouse for Alcohol Information, Station IL, PO Box 2345, Rockville MD 20852.

NUCLEAR MEDICINE EDUCATION

The American College of Nuclear Physicians has instituted a professional and public information program on nuclear medicine and related low-level nuclear waste disposal issues. The College is seeking to educate the non-nuclear medical community and referring physicians through their speakers bureau. Speakers bureau members will address these topics at no charge before major medical society meetings. Information may be obtained by writing the College at Suite 700, 1101 Connecticut Avenue NW, Washington D.C. 20036.

PAPER COMPETITION ANNOUNCED

The Rhode Island Medical Society is accepting papers for their Fiske Prize. The award of up to $2,500 has been offered annually since 1836; 86 recipients have been honored in that time. The topic for papers is: "A Current Technological Innovation and Its Impact on Medicine." Papers must be submitted prior to August 15, 1984. They should be in duplicate, double spaced and may not exceed 10,000 words. Copyright privileges must be transferred to the Society. Requests for further information may be directed to Marion Sabella, Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nitedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PRDCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PRDCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PRDCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PRDCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nifedipine. PRDCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

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**Additional NMR Information on page 427*

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 165, No. 6
June 1984

In Wounds Sutured in the Emergency Department

Effect of Cap and Mask on Infection Rates

By John C. Ruthman, M.D., David Hendricksen, M.D., Ph.D., Richard F. Miller, M.D. and David L. Quigg, Ph.D./Peoria

We describe a prospective study of 508 lacerations repaired in our emergency department in which surgical cap and mask were worn on alternate weeks only. Follow-up information regarding wound outcome was obtained on 442 (87%). A total of 239 lacerations had been repaired by an operator wearing a cap and mask (Group I), while the other 203 were repaired without use of cap or mask (Group II). Our overall infection rate was 3.2%. There was no significant difference in infection rates between our study groups.

There exists an unexplained discrepancy in the way lacerations are managed in many American hospitals. While surgical caps and masks are worn routinely in the operating room, these implements are often not used in the emergency department. Presumably, this is due to the impression that their use would be unlikely to affect infection rates in traumatically incurred lacerations. Little data exists to support or refute this contention.

Methods and Materials

All lacerations sutured by emergency department residents and attending physicians were included unless they were (a) more than 12 hours old, (b) associated with other injuries such as fractures, nerve or tendon injury or (c) caused by human bites. Operating physicians wore surgical cap and mask on alternate weeks only. Surgical gloves were worn by all physicians on all wounds.

Each laceration was cleansed for four minutes with a commercial chlorhexidine gluconate solution by a nurse wearing surgical cap, mask and sterile gloves. Saline irrigation and debridement techniques were left to the discretion of the individual physician. Prophylactic antibiotics were not used. Information regarding the patient, type and location of wound, degree of contamination and use of cap and mask were recorded on a special form. Prior to discharge, all wounds except those of the scalp, were covered with sterile dressings which patients were instructed to keep clean and dry. Follow-up care, including suture removal, was arranged with the patient's private physician or with an assigned staff surgeon in cases where no private physician existed.

Self-addressed pre-stamped postcards (Figure 1) on which wound outcome was reported were mailed to the physician responsible for follow-up. Where no postcard was received within two weeks, the follow-up physician's office was called for a description of the laceration at suture removal. Where patients failed to appear for follow-up, an attempt was made to contact them for close questioning regarding wound appearance. Follow-up data placed each wound into one of four categories, grades zero through three (Figure 1). Wounds classified as grades 0 or 1 were considered healed without infection, while those in grades 2 or 3 were considered wound infections.

Results

There were 508 lacerations entered into the study. Of these,

Figure 1
Dear Doctor:
This patient was sutured in our hospital emergency room today. We are monitoring our infection rate, and would, therefore, appreciate your completing and returning this card. Use one check mark per laceration. Thank you.
Grade
0. _____ No evidence of infection
1. _____ Minimal inflammation, not considered significant
2. _____ Moderate inflammation, not requiring antibiotics
3. _____ Frank infection, requiring antibiotics

follow-up information was obtained on 442 (87%). A total of 239 lacerations were repaired by an operator wearing a surgical cap and mask (Group I), while the other 203 were repaired without cap or mask.

Data regarding location, degree of contamination, type of laceration, and presence or absence of infection is presented in Table 1 for each group. The groups were similar with respect to these variables (Table 2). We have not attempted to study or tabulate sociological variables for the two groups.

A total of 14 wound infections were reported for an overall infection rate of 3.2%. Of these infections, six occurred in Group I (2.5%) and eight occurred in Group II (3.9%). This difference is not statistically significant.

To further verify the group comparison, we introduce a statistical model appropriate to the possibly complex dependencies among the recorded variables. We apply the loglinear model as described in Fienberg[1] using the BMDP[2] statistical computer program P3F. Statistical significance in a loglinear model is measured using the LR (likelihood ratio) Chi-square test.

One highly significant term in the resulting model is the three factor interaction between contamination, location and type of wound. That is, the probability that a randomly selected case will be in a particular cell of Table 1 depends not only on these three factors individually and in pairs, but also on all three together.

In loglinear models for the data with the CLT (contamination-location-type) factor included, there is again no statistically significant difference in infection rates between Group I and Group II. Only contamination of the wound is even moderately related to subsequent infection, and this with a statistical significance of approximately .06.

Table 1
Patient Categorization

	Type	Location	Infection	Contamination		
				None	Min	Mod/Sev
Group I	Sharp	Extremity	No	37	21	7
(Cap and Mask)			Yes	1	1	0
		Trunk, head, neck	No	48	13	2
			Yes	0	1	1
	Blunt, crushed	Extremity	No	7	10	9
			Yes	0	0	1
		Trunk, head, neck	No	22	20	3
			Yes	0	1	0
	Flap	Extremity	No	17	11	3
			Yes	0	0	0
		Trunk, head, neck	No	0	2	1
			Yes	0	0	0
Group II	Sharp	Extremity	No	45	16	1
(No Cap, No Mask)			Yes	3	1	0
		Trunk, head, neck	No	35	9	1
			Yes	0	0	0
	Blunt, crushed	Extremity	No	11	8	7
			Yes	0	0	1
		Trunk, head, neck	No	25	18	6
			Yes	0	1	1
	Flap	Extremity	No	7	4	1
			Yes	1	0	0
		Trunk, head, neck	No	0	0	1
			Yes	0	0	0

Table 2
Group Comparisons

Wound Parameter	Group I (239 patients)		Group II (203 patients)	
	Total Number	Percent	Total Number	Percent
A. Contamination				
None-minimal	212	88.7	184	90.6
Moderate-severe	27	11.3	19	9.4
B. Location				
Extremity	125	52.3	106	52.2
Trunk, head, neck	114	47.7	97	47.8
C. Type				
Sharp	132	55.2	111	54.6
Blunt, crushed	73	30.5	78	38.4
Flap	34	14.2	14	6.9

Only one additional other factor approaches statistical significance in the loglinear model for the data in Table 1. Group I and Group II differ (significance .025, LR Chi-square test) with respect to the type of laceration sutured. The inclusion of this factor has no effect on the results noted in the preceding paragraphs.

Discussion

In a letter to the editor, Caliendo[3] described an informal study on lacerations he sutured as an emergency medicine resident. He wore a surgical mask on alternate lacerations. Only one wound infection was reported in his series of 92 patients (in a case for which he had worn a mask). The limitations of his study are apparent. However, the authors can find no other series in the literature on this subject to date.

Our overall infection rate of 3.2%, as well as the infection rate in each of our study groups, compares favorably with other series.[4-6]

Groups I and II were highly similar with respect to wound location and percentage of wounds judged to be moderately or severely contaminated at initial treatment. The only difference between the groups was seen in the number of flap-type lacerations, which predominated in Group I. As there was only one infection in all flap lacerations, (that one occurring in Group II) we do not feel that this had significant impact.

In the design of our study, wound outcome evaluation was done by multiple observers. In our community, emergency department patient follow-up, including suture removal, has traditionally been done by private practitioners. We have attempted to unify the assessment of wound outcome through the use of the checklist shown in Figure 1.

At no time were nasal or pharyngeal cultures obtained on emergency department physicians. We also do not have data regarding the specific pathogens responsible for our 14 wound infections.

Conclusion

These data suggest that the routine use of surgical cap and mask for wounds repaired in the emergency department does not significantly affect infection rate. ◀

Acknowledgements

The authors wish to thank the emergency department nurses at St. Francis Medical Center, Lisa O'Neal, and especially Elaine Cook.

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In Optic Neuritis

Computerized Tomography of the Orbits

By Karen Scardigli, D.O., José Biller, M.D., Berhooz Azar-Kia, M.D. and Marcel Frenkel, M.D., Chicago and Maywood

We describe a 24-year-old female with a demyelinating optic neuropathy. Computerized tomography of the orbits demonstrated right optic nerve enlargement which assumed normal proportions with clinical improvement of the patient.



Figure 1A

A 24-year-old woman was admitted with a three week history of blurred vision occurring in the right eye accompanied by difficulty focusing and occasional pain with movement of the right eye. Past medical history was noncontributory except for a "congenital" head tilt.

General physical examination was unremarkable with the exception of a left head tilt. Neurologic examination revealed normal mental status, speech and language. Visual acuity was 20/100 in the right eye and 20/20 in the left. A superior oblique paresis was noted on the right. A pupillary afferent defect (Marcus Gunn pupil) was evident on the right as well as red desaturation. Funduscopic examination was remarkable for slight temporal pallor of the right optic disc. Visual fields revealed a right central scotoma. The remainder of the cranial nerve examination was normal. Motor, sensory, gait and station, and cerebellar examinations were normal. Muscle stretch reflexes were normoactive and symmetrical; abdominal reflexes were symmetrically present. Plantar responses were flexor bilaterally.

General laboratory data including sedimentation rate, ANA, rheumatoid factor, thyroid function studies and serum protein electrophoresis were normal. RPR was non-reactive. The cerebrospinal fluid was clear under normal pressure with five white blood cells, 2% lymphocytes.

Glucose and protein were normal. CSF cultures and cryptococcal screen were negative. CSF IgG was elevated at 16.5% (normal: 0.5-6.1) and the calculated IgG index was increased with a value of 1.86. IgG index was calculated as (CSF IgG/albumin)/(serum IgG/albumin) (values of 0.66 or more are considered abnormal) Myelin basic protein was mildly increased at 6.1; oligoclonal bands were not present. Visual evoked responses to pattern reversal stimulation yielded a significantly delayed and attenuated response in the right eye, with P-1 peaks delayed to 125 milliseconds. Brainstem auditory and somatosensory evoked responses were normal. Polytomes of the optic canals were normal. Computerized tomography of the head and orbits in the coro-



Figure 1B

nal plane demonstrated asymmetry of the optic nerves, with the right appearing more prominent than the left (Figure 1A).

The patient received intramuscular ACTH (80 units/day) for ten days. Examination at discharge revealed the visual acuity in the right eye to be improved at 20/40. Resolution of the right central scotoma and minimal red desaturation was still appreciated. Coronal computerized tomography of the orbits was repeated three weeks following discharge and demonstrated symmetry of the optic nerves (Figure 1B).

Comment

The clinical presentation, objective findings, and laboratory data in the case described are compatible with a diagnosis of demyelinating optic neuropathy. Of particular interest is the finding of right optic nerve enlargement on computerized tomography, which assumed normal proportions with clinical improvement.

Eyerman, *et al*,[1] detected hyperdense beads or bulges alternating with low density constrictions and isodense swellings of the nerves in retrobulbar neuritis. Mosely and Sanders[2] have noted thickened optic nerves in optic neuritis and have seen one patient with optic neuritis in whom a thick nerve was seen initially and a further CT scan showed resolution of the nerve swelling with concurrent visual improvement. Computerized tomography in patients with optic neuritis has been used primarily to exclude primary tumors of the nerve sheath or secondary infiltration by granuloma or tumor. We suggest that computerized tomography of the orbits may be used in the diagnosis and follow-up of patients with demyelinating optic neuropathy, as demonstrated in our patient.

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Together We Can Make a Difference!

Communicate

By Vivian Reardon, ISMSA President

For the past 56 years, the ISMS Auxiliary has communicated in the name of medicine with its members and with the people of Illinois. We must continue that communication. Never has it been more important for us to cooperate and to speak loudly for continued quality medical care. Never has it been more important for us to address the changing needs of our members.

Medicine today is under universal scrutiny. By government directive, the spouses of physicians are classified as providers of medical care. Although we provide no care, the world does expect us to be knowledgeable about the delivery of medicine. We must become informed and we must become articulate. No one else will expound our viewpoint. It behooves us to draw on the best resource of medical knowledge today—our physician spouses. It behooves us to be able to speak intelligently about medical issues with all we meet—friends, legislators, employers and employees. We must be prepared to address inquiries as the occasion demands. If we do this, the auxiliary can become the strongest support medicine has today.

Our attitude of concern is demonstrated continually in our communities, where we have raised thousands of dollars for local scholarships, and where we sponsor innumerable health projects under the umbrella theme, "Shape Up For Life." Our numbers are limited, but we are networking with other organizations to ensure dissemination of accurate medical information. Through community health projects, we, the advocates of American medicine, are promoting good health habits for all. Other projects take health related knowledge directly to the consumer.

Our concern also extends to our members and the medical community itself. For several years we have taken a look at the benefits and problems unique to the physician's family. Through greater understanding, we have aimed to improve the quality of living for our families. We plan to move forward and investigate how we can best support those members of the medical community facing the special problems of retirement, widowhood, and the ever increasing spectre of malpractice. As the physician is under greater pressure, so is the medical family. We intend to increase our activities as a support group.

Today there is a greater need than ever to work in unison. Therefore, during this 57th year auxilians are asked to make an even greater effort to:

- communicate with each other;
- communicate with their medical societies;
- communicate with their communities.

By communicating and working together, we can make a difference! ◀

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1984 Annual Meeting House of Delegates

The ISMS House of Delegates met at the Chicago Marriott Hotel in Chicago, April 6-8, 1984, and took the following actions. The official minutes of the House are on file at the Illinois State Medical Society office.

UNFINISHED BUSINESS

6 (A-83)—Not Adopted
(BOT Report B)—Develop Three Ambulance Classifications in Illinois
Reported by Warren D. Tuttle, M.D., for the Board of Trustees

Defeated this resolution which called upon ISMS to pursue changes in State of Illinois law to permit and encourage operation of ambulances which can be used for transporting of patients without the need of highly trained personnel and expensive lifesaving equipment.

12 (A-83)—Not Adopted
(BOT Report C)—Health Insurance Benefits Spelled Out
Reported by Warren D. Tuttle, M.D., for the Board of Trustees

Defeated this resolution which called upon ISMS to recommend action to the Illinois General Assembly and the Illinois Insurance Department to require that health insurance subscribers be given specific accounting of the benefits contained in their insurance policies in the simple English language so that they know specifically what is covered by the policies and in what amount or percentages.

15 (A-83)—Referred to Ref. Comm. A
(BOT Report D)—Mandatory Levels of Liability Insurance
Reported by Warren D. Tuttle, M.D., for the Board of Trustees (See Res. 42 (A-84) in Report of Ref. Com. A)

20 (A83)—Adopted
(BOT Report E)—Chronic Care Patients
Reported by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that ISMS encourage medical school curricula and residency training programs to address the issues of utilization of community resources, and the strategies for dealing with the long-term medical, rehabilitation and social needs of chronic care patients.

Report F Adopted in Lieu of Res. 22 (A-83) & 23 (A-83)
(BOT Report F)—Anti-Trust Laws and Federal Trade Commission
Reported by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that ISMS continue to support AMA efforts to clearly define anti-trust laws and FTC authority over the learned professions.

Substitute 24 (A-83)—Adopted as Editorially Amended
(BOT Report G)—Conflicts Between ISMS Bylaws and the Judicial Panel HANDBOOK FOR THE CONDUCT OF DISCIPLINARY PROCEEDINGS
Reported by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that Chapter XI of the ISMS Bylaws and Section IV of the Judicial Panel's HANDBOOK FOR THE CONDUCT OF DISCIPLINARY PROCEEDINGS be amended as follows:

CHAPTER XI. ETHICAL RELATIONS

Part 4. Standards and Procedures.

B. Disciplinary action may be initiated by the component society or the ISMS upon receipt of formal written charges filed by any person, alleging violations of any of the offenses enumerated in Part 3 of this Chapter. The person filing the complaint may submit it to either the county where the accused physician holds membership or the county where the alleged incident occurred.

Part 5. Penalties. The component society's or District Ethical

Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: a) acquit; b) censure; c) suspend; or d) expel from membership.

Also directed that the following be added to Chapter XI of the ISMS Bylaws:

Appeals to the Judicial Panel. A notice of appeal shall be filed with the ISMS Judicial Panel by one of the parties within 30 days after receiving notice of a decision from the component society. Within 15 days after the required filing date for appeal, the party requesting the appeal shall file a written statement with the Judicial Panel which shall include a description of the errors believed to have occurred during the prior proceedings or assertations of the substantive grounds for requesting the Appellate Hearing. A party may be granted an appeal hearing if: 1) There is reason to believe that procedural error(s) occurred which significantly affected the outcome of the case; 2) There is a showing that those who conducted the initial hearing acted with bias; 3) The evidence upon which the decision was based was not sufficient to support the decision; 4) The evidence was not properly received or considered; or 5) In the sole discretion of the Judicial Panel, there were other reasons which adversely governed the proceedings and denied due process rights to the party requesting the appeal.

34 (A-83)—Not Adopted
(BOT Report H)—Good Samaritan Legislation for Medically Indigent Programs
Reported by Warren D. Tuttle, M.D., for the Board of Trustees

Defeated this resolution which called upon ISMS to introduce and/or support "Good Samaritan" legislation in the Illinois General Assembly which would provide immunity or other restriction from civil liability for physicians and other health care professionals who, in good faith, provide medical services through such special programs for the medically indigent as long as local community standards of reasonable care are exercised.

35 (A-83)—Referred to Ref. Comm. C
(BOT Report I)—Freestanding Emergency Centers
Reported by Warren D. Tuttle, M.D., for the Board of Trustees (See Res. 43 (A-84) in Report of Ref. Com. C)

REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

1 (A-84)—Referred to Board for Study
Eligibility for Retired Member Status
Introduced by Raymond E. Hoffmann, M.D. for the Winnebago County Medical Society

Referred to the Board of Trustees for study a proposal to seek amendments to the bylaws allowing retired status to a physician who is in: (1) A compensated position in a health care related field representing less than ten (10) hours of work per week; or (2) Any compensated position in a non-health care related field.

2 (A-84)—Adopted as Amended
Board of Trustees Committee on Building and Capital Equipment
Introduced by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that Chapter IX of the ISMS Bylaws be amended as follows:

CHAPTER IX, COMMITTEES
Section 8. Board of Trustees Committees.

H. The Building and Capital Equipment Committee shall consist of the Chairman of the Board, the President, the President-Elect, the Secretary-Treasurer, the Chairman of the Finance Committee, and the Immediate Past Chairman of the Board, provided that person is a trustee. The Committee shall review and monitor activities pertaining to the building and capital equipment.

I. The Board of Trustees may from time to time appoint such ad hoc committees . . .

3 (A-84)—Adopted as Editorially Amended
Amendment to Chapter IX, Section 5 of the ISMS Bylaws
Introduced by Warren D. Tuttle, M.D. for the Board of Trustees

Directed that Chapter IX of the ISMS Bylaws be amended as follows:

CHAPTER IX, COMMITTEES
Section 5. Committees Reporting Directly to the Board of Trustees

H. Committee on Hospital Medical Staffs. The committee shall address the concerns of and develop programs for ISMS members as physicians on hospital medical staffs in their association with the administration and governing boards of hospitals. The committee shall keep abreast of developments in hospital-medical staff relationships; monitor and work with the AMA Hospital Medical Staff Section and ongoing efforts organized by component medical societies; and to the extent feasible, provide informal liaison with organizations impacting on Illinois hospital medical staffs.

Also directed that: (1) The Committee on Hospital Medical Staffs include ten (10) representatives from the Illinois AMA/HMSS delegation; and (2) This direct reporting committee replace the existing ISMS Ad Hoc Committee on Hospital Medical Staffs, thus performing as the hospital medical staff committee within ISMS.

ATTENDANCE

The Credentials Committee recorded attendance of the 1984 House of Delegates as follows:

	First Session	Second Session	Third Session
Officers & Trustees	26	24	22
Speaker & Vice Speaker	2	2	2
Delegates:			
District 1	7	10	8
District 2	9	8	6
District 3	102	107	99
District 4	9	12	12
District 5	7	8	3
District 6	6	5	4
District 7	4	4	2
District 8	9	9	6
District 9	5	5	3
District 10	6	5	4
District 11	10	8	8
District 12	9	10	8
Intern/Resident	0	0	1
Student	0	1	1
TOTAL	211	218	189

7 (A-84)—Adopted
Policy Statement on "Autopsies"
Introduced by Warren D. Tuttle, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement to read:

Autopsies

Because the autopsy has public health and educational benefits for medical science, the family of the deceased individual and the public at large, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.

8 (A-84)—Adopted
Policy Statement on "The Privacy of Physician Records"
Introduced by Warren D. Tuttle, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement to read:

Physician Records, Privacy of

The Illinois State Medical Society will take appropriate action to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts or other confidential business records without appropriate authority assuring due process.

17 (A-84)—Referred to Board for Study
Reduced Dues
Introduced by Raymond A. Dieter, Jr., M.D. for the DuPage County Medical Society

Referred to the Board of Trustees for study a proposal that only partial dues shall be assessed in the instance of a member, who, due to illness or age, devotes a very limited number of hours to medical practice.

18 (A-84)—Referred to Board for Study
Waived Dues
Introduced by Raymond A. Dieter, Jr., M.D. for the DuPage County Medical Society

Referred to the Board of Trustees for study a proposal that dues be waived for members who meet all requirements for retired status except that they have taken a compensated position outside of medicine.

28 (A-84)—Not Adopted
Unified Membership
Introduced by Steven Macke, M.D., for the Clark County Medical Society

Defeated this resolution which called upon ISMS to amend its bylaws regarding membership requirements by deunifying from the American Medical Association.

31 (A-84)—Not Adopted
Optional Membership At All Levels of Organized Medicine
Introduced by Manual O. Guerrero, M.D., for the Rock Island County Medical Society

Defeated this resolution which called upon ISMS to make membership optional at all three levels by amending its bylaws to eliminate the requirement that members must join the component society, the Illinois State Medical Society and the American Medical Association.

38 (A-84)—Not Adopted
Unified Membership with AMA
Introduced By Larry R. Jones, M.D., for the Saline-Pope-Hardin County Medical Society.

Defeated this resolution which called upon ISMS to amend its bylaws so as to make membership in the American Medical Association optional rather than compulsory for members and potential members of ISMS.

Reports
Filed the following reports for information:
Committee on Constitution & Bylaws, Policy Committee and Judicial Panel.

REFERENCE COMMITTEE A

11 (A-84)—Adopted
Legal Drinking Age—National Unification
Introduced by Lewis Trupin, M.D., Harlan Failor, M.D. and Robert Welke, M.D., for the Champaign County Medical Society

Directed that ISMS: (1) Call for a uniform national legal drinking

age of 21 years to be established by all states; and (2) Introduce a similar resolution to the AMA House of Delegates.

16 (A-84)—Adopted as Amended
Confidentiality of Medical Staff Committee Records
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Directed that ISMS take all appropriate action to preserve the confidentiality of records and activities of medical staff committees.

19 (A-84)—Not Adopted
Care of Needy and Liability Suits
Introduced by Raymond A. Dieter, Jr. M.D., for the DuPage County Medical Society

Defeated this resolution which called upon ISMS to seek legislative protection against non-meritorious liability suits which may result from the care rendered by a competent physician, in good faith, for patients who are medically indigent or on Public Aid, as long as the local community standards of reasonable care are exercised.

20 (A-84)—Referred to Board for Study
Insanity As A Defense
Introduced by Kishore Thampy, M.D.

Referred to the Board of Trustees for study a proposal that: (1) ISMS adopt the position that the use of the insanity defense constitutes a legitimate basis to absolve criminal responsibility; and (2) That this position be introduced in a similar resolution to the AMA House of Delegates.

24 (A-84)—Referred to Board for Study
Patient Communication
Introduced by Harry A. Springer, M.D., Chairman, Cook County Delegation

Referred to the Board of Trustees for study a proposal that: (1) The statement: "ISMS believes that any decision that could affect the medical care of a patient should be reported to the patient or his/her legal representative by the person, persons, or organization making the decision; (2) This policy be made part of the Policy Manual of the ISMS; and (3) The public be informed of this policy and the Society's stand on behalf of patients.

25 (A-84)—Not Adopted
Protection of Physicians' Hospital Staff Appointments and Privileges
Introduced by Donald W. Aaronson, M.D.

Defeated this resolution which called upon ISMS to cause to be introduced into the Illinois General Assembly legislation which would guarantee proper substantive and procedural judicial review in the event of a denial of or reduction of a physician's hospital privileges when that physician seeks such review.

34 (A-84)—Adopted as Amended
Apprehending Physicians With Illegally Obtained Medical Degrees
Introduced by Michael L. Nieder, M.D., for the Resident Physicians Section

Directed that the Illinois Delegation to the American Medical Association request the AMA to work closely with and assist the appropriate governmental agencies in the identification of physicians possessing illegally obtained medical degrees.

35 (A-84)—Adopted as Amended
Cigarette Smoking Hazards
Introduced by John Mason, M.D.

Directed that ISMS: (1) Establish a policy and work with other agencies to publicly advocate a vigorous stand that cigarette smoking is a major known health hazard and a remediable factor in the high cost of health care; and (2) Introduce a similar resolution to the AMA House of Delegates.

36 (A-84)—Adopted by Acclamation
Candidacy of Joseph H. Skom, M.D. for Re-Election to the AMA Council on Scientific Affairs
Introduced by Howard C. Burkhead, M.D.

Directed that: (1) The Society enthusiastically endorse the candidacy of Dr. Joseph H. Skom for re-election to the AMA Council on Scientific Affairs; and (2) The Society's official endorsement of Dr. Skom be communicated to the members of the AMA House of Delegates.

37 (A-84)—Adopted by Acclamation
Candidacy of Dr. Ronald M. Davis for AMA Resident Trustee
Introduced by Howard C. Burkhead, M.D.

Directed that: (1) The Society enthusiastically endorse the candidacy of Dr. Ronald M. Davis for the position of resident trustee of the AMA; and (2) The Society's official endorsement of Dr. Davis be communicated to the members of the AMA House of Delegates.

42 (A-84)—(Board Rep.D) Adopted in Lieu of Res. 15(A-83)
Mandatory Levels of Liability Insurance
Introduced by Warren D. Tuttle, M.D. for the Board of Trustees

Directed that: (1) The Society reaffirm policy pertaining to required liability insurance by hospitals; and (2) The Board of Trustees develop a mechanism through appropriate councils and committees to assist hospital medical staffs in addressing the issue of required liability insurance as a condition of staff privileges.

Reports
Filed the following reports for information:
President, President-Elect, First Vice President, Second Vice President, Secretary-Treasurer, Chairman, Board of Trustees, Trustees, Executive Administrator, AMA Delegation, AMA Delega-

tion Supplemental Report, Advisory Committee to Auxiliary, Illinois Society, American Association of Medical Assistants, Governmental Affairs Council, Medical-Legal Council, Task Force on Membership Marketing, Committee on Insurance, Illinois State Medical Insurance Services, Inc. and Illinois Department of Registration and Education.

REFERENCE COMMITTEE B

4 (A-84)—Adopted as Editorially Amended
Physician Reimbursement (UCR)
Introduced by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that ISMS: (1) Support the individual physician's right to choose the method of economic reimbursement for care that best suits the needs of that physician and his/her patients, in order to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician and his/her patients; (2) Support, where appropriate, the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays; and (3) Strive, to the extent practicable, to assist physicians in understanding alternative reimbursement systems.

9 (A-84)—Adopted
Alice Hamilton, M.D. Commemorative Stamp
Introduced by Harry A. Springer, M.D., for the Chicago Medical Society

Directed that: (1) ISMS support a commemorative stamp honoring Dr. Alice Hamilton as a pioneer in occupational medicine; and (2) This resolution be submitted to the AMA requesting support of the Dr. Alice Hamilton Commemorative Stamp.

10 (A-84)—Adopted as Amended
Enabling Action for PPO Promulgation
Introduced by Lewis Trupin, M.D., Harlan Failor, M.D. and Robert Welke, M.D., for the Champaign County Medical Society

Directed that the ISMS Board of Trustees review PPO legislation and take the necessary actions to assure that physicians can compete as equals with all others in the medical marketplace.

Substitute 15 (A-84)—Adopted
Exclusive Provider Organizations
Introduced by William P. Gibbons, M.D., for the DuPage County Medical Society

Directed that ISMS monitor the development of HMOs, IPAs, PPOs and EPOs in Illinois and have this information available to assist ISMS members in their relationships with these organizations.

21 (A-84)—Not Adopted
HMOs for Medicaid Patients
Introduced by Samuel J. Schimel, M.D.

Defeated this resolution which called upon ISMS to promote legislation to assist Medicaid patients' free choice of medical care facilities and physicians.

Substitute 22 (A-84)—Adopted
DRGs Effect on Senior Citizens
Introduced by Samuel J. Schimel, M.D.

Directed that the Illinois Delegation to the AMA seek AMA action to monitor closely potential quality of care problems caused by the DRG reimbursement system and to take appropriate steps to alleviate these problems expeditiously.

Substitute 29 (A-84)—Adopted
Informing Patients of Fees
Introduced by Albert W. Ray, Jr., M.D., for the Will-Grundy County Medical Society

Endorsed the principle that, where feasible and desirable, physicians should provide patients with information regarding fees and, where practicable, discuss this information prior to providing care.

40 (A-84)—Adopted
DRG Payments and Cost of Procedures
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Directed that the Society encourage hospitals to establish a mechanism whereby physicians will have ready access, upon admission of patients, to information about expected DRG payments and charges for hospital procedures.

Substitute 41 (A-84)—Adopted as Amended
Physician Fee Freeze
Introduced by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that the Society support the AMA Board of Trustees' recommendation to encourage the medical profession to freeze their fees for one year.

Reports
Filed the following reports for information:
Council on Economics, Third Party Payment Processes Committee, Committee on Health Planning and Committee on Drugs and Therapeutics.

REFERENCE COMMITTEE C

5 (A-84)—Adopted
Support for Voluntary Continuing Medical Education in Illinois
Introduced by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that the Society continue its strong support of voluntary CME in Illinois and the intrastate accreditation of quality CME programs.

6 (A-84)—Adopted as Editorially Amended
Hospital Education Programs for Care and Treatment of Infants Born with Disabilities
Introduced by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that the Society urge all Illinois medical staffs to develop and conduct educational programs for their members involved in the care of handicapped infants, including advances in neonatal care, as well as laws and regulations affecting the delivery of these infants.

Substitute 12 (A-84)—Adopted
American Cancer Society Proposed Cancer Patient Hotline Referrals
Introduced by Robert Wanless, M.D., for the St. Clair County Medical Society

Directed that the Society: (1) Inform the American Cancer Society and its component Illinois societies of its objection to a referral system which may breach existing physician-patient relationships; and (2) Encourage the American Cancer Society and its Illinois Chapters to work with the available local medical communities in providing referral and treatment of cancer patients.

Substitute 13 (A-84)—Adopted in Lieu of 13 (A-84) and 30 (A-84)
Illinois Office of Education Proposal to Eliminate Mandatory 5th and 9th Grade Medical Examinations
Introduced by Robert Wanless, M.D., for St. Clair County Medical Society
Proposed Changes in the School Health Mandates
Introduced by William E. Kobler, M.D., for Winnebago County Medical Society

Directed that the Society: (1) Continue to support the need for physical examinations of, and updating of immunizations for school children in the State of Illinois on school entry at 5th grade and at 9th grade levels, in keeping with preventive medicine measures presently in existence in the State of Illinois; and (2) Support measures to assure that compliance of the school health mandates by school districts in Illinois be maintained.

14 (A-84)—Adopted as Editorially Amended
AIDS and Blood Donations
Introduced by Thomas Harwood, M.D.

Directed that ISMS: (1) Use its publications to assist physicians to educate their patients that donating blood does not expose the donor to the risk of AIDS; (2) Adopt the position that "designated blood donations" are an inappropriate means of dealing with the AIDS problem and inordinately tie up blood supplies; and (3) Introduce the essence of this resolution to the AMA House of Delegates.

23 (A-84)—Adopted as Amended
Prenatal Environment for the Child
Introduced by Henrietta Herbolsheimer, M.D.

Directed that ISMS: (1) Adopt the policy that public concern about the effect of the environment on human health be expanded to include concern for a healthy intrauterine environment for the early development of each child; and (2) Bring this statement to the attention of the public through the schools, the media in Illinois, and members of the General Assembly.

Substitute 26 (A-84)—Adopted
Mandatory CPR and First Aid Training
Introduced by Karen Kawala for the Medical Student Section

Directed that ISMS endorse the concept that persons responsible for monitoring or instructing others in health and fitness facilities be certified in basic Cardiopulmonary Resuscitation.

Substitute 27 (A-84)—Adopted
Acquired Immune Deficiency Syndrome
Precautions for Clinical and Laboratory Staffs
Introduced by Karen Kawala for the Medical Student Section

Directed ISMS to request that the American Medical Association's Section on Medical Schools urge its members to disseminate to medical students the Centers for Disease Control Guidelines delineating precautions for patients with potentially transmittable diseases, such as AIDS.

32 (A-84)—Not Adopted
For-Profit Hospital Care
Introduced by Michael L. Nieder, M.D., for Resident Physicians Section

Defeated this resolution which called upon the Society to request that the AMA: (1) Assess the quality of medical education programs at for-profit hospitals; and (2) Study the issue of funding for teaching hospitals and develop and disseminate plans and suggestions for the continued independent function of same.

33 (A-84)—Not Adopted
Graduate Education in Trouble
Introduced by Michael L. Nieder, M.D., for Resident Physicians Section

Defeated this resolution which called upon the Society to request that the AMA support the findings of the National Commission on Student Financial Assistance and lobby in Congress for increased unrestricted federal funding for basic and applied research at colleges and universities.

43 (A-84)—(Board Rep.I) Adopted in Lieu of Res. 35(A-83)
Freestanding Emergency Centers
Introduced by Warren D. Tuttle, M.D., for the Board of Trustees

Directed that the Society not sponsor legislation to regulate the use of the term "emergency," but wait until the Illinois Chapter of the American College of Emergency Physicians' legislation is introduced, and then take

action on this issue through the legislative process, which is exempt from anti-trust actions.

Reports

Filed the following reports for information:

Council on Medical Services, Council on Mental Health & Addiction, Council on Education & Manpower, Committee on Accreditation, Ad Hoc Committee on Hospital Medical Staffs, Loss Prevention Committee, Publications Committee, Task Force on Health Professions, Task Force on Financial Aid to Medical Students, Student Loan Fund, Committee on Impaired Physicians, Resident Physicians Section, Medical Student Section, Illinois Council on Continuing Medical Education (ICCME), Educational & Scientific Foundation, Illinois Department of Public Health, Illinois Department of Mental Health & Developmental Disabilities, Division of Rehabilitation Services, Dangerous Drugs Commission, Department of Aging and Illinois Department of Children & Family Services.

MEMORIAL RESOLUTIONS

The House also adopted memorial resolutions in memory of Drs. Walter C. Bornemeier, and Alphonso L. Robinson, and expressed its profound loss and condolences to their families.

ELECT OFFICERS, TRUSTEES, AMA DELEGATES

Dr. Robert C. Hamilton, Chicago, was installed as ISMS president, succeeding Dr. Robert P. Johnson, Springfield.

Election of Officers

At the concluding session of the House, 1984-85 officers were elected unanimously. They are: Drs. Morgan M. Meyer, Lombard, president-elect; Jere E. Freidheim, Chicago, 1st vice president; Ronald G. Welch, Belleville, 2nd vice president; Alfred J. Kiessel, Decatur, secretary-treasurer; Julian W. Buser, Belleville, speaker of the House and Lawrence L. Hirsch, Chicago, vice-speaker of the House.

Election of Trustees

Elected trustees were: Drs. David B. Littman, first district; Alfred J. Clementi, Joan E. Cummings, Arthur R. Peterson and Cyril C. Wiggishoff, third district; George T. Wilkins, sixth district; Warren D. Tuttle, ninth district; and Thomas P. Meirink, tenth district.

Judicial Panel

Dr. Arthur R. Fischer, Berwyn, was elected to serve a five year term on the ISMS Judicial Panel.

Illinois AMA Delegates

The House of Delegates elected AMA delegates and alternates to serve January 1, 1985 through December 31, 1986. Elected delegates were: Drs. Audley F. Connor, Jr., David S. Fox, Henrietta Herbolsheimer, Lawrence L. Hirsch, Michael L. Nieder, Joseph R. O'Donnell, P. John Seward, Fred Z. White and George T. Wilkins. Alternate delegates were: Drs. James H. Andersen, James R. DeBord, Alfred J. Kiessel, Carlos B. Lara, Joseph B. Perez, Clifton L. Reeder, Harry A. Springer, Robert M. Vanecko and Ms. Nancy Zamora.

Complete Unexpired Terms

Dr. Fred Z. White was elected to serve Dr. John J. Ring's unexpired term as delegate which runs through 1984. Dr. Carlos B. Lara was elected to serve Dr. White's unexpired term as alternate which runs through 1984.

1985 Dues

The Secretary-Treasurer announced that the per capita dues for 1985 were set at $253.



Julian W. Buser, M.D., Belleville, Speaker of the House, addresses the assembly.



ISMS Past Presidents gather for the annual gourmet dinner. Standing (L-R) are Joseph H. Skom, M.D., J.M. Ingalls, M.D., P. John Seward, M.D., George T. Wilkins, M.D., Herschel Browns, M.D. and David S. Fox, M.D. Seated (L-R) are Newton DuPuy, M.D., Fred Z. White, M.D., Cyril C. Wiggishoff, M.D., Willard C. Scrivner, M.D., and J. Ernest Breed, M.D.

Annual Meeting Highlights



Robert P. Johnson, M.D. (L) installs Robert C. Hamilton, M.D., as the 1984-85 president of the Illinois State Medical Society. In his inaugural address, Dr. Hamilton told the House: "The greatest challenges of any administration are generally those that couldn't have been predicted when the term began. . . . I hope to stand here at this time next year and tell you, 'I'm glad it happened on my watch.' "



Warren D. Tuttle, M.D., Harrisburg, Chairman of the Board of Trustees, reports on current business.



Illinois Attorney General Neil Hartigan thanks the Society for its support of law enforcement efforts to curb Medicaid fraud.



Members of the 1984-85 ISMS Auxiliary Board. In her parting address, outgoing president Susanne Webb thanked the Society for its support of Auxiliary goals and projects.

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a sixty three year old man who arrived at the emergency service in full cardiac arrest. The cardiac arrest occurred at home. Members of his family began cardiopulmonary resuscitation before the team of paramedics arrived. The arrhythmia was ventricular fibrillation on arrival and the patient was successfully defibrillated. He was also intubated and placed on a respirator. During the cardiac arrest, potassium was 4.4 mEq/liter and his pH was 6.99. He was alert at the time of admission to the coronary care unit. An intravenous dobutamine infusion was titrated to keep the systolic blood pressure at 100 to 110 mmHg. Examination of the lungs showed bibasilar crepitant rales and the heart had a ventricular gallop (S_3). Past history obtained from the patient's family at this time included a myocardial infarction twelve years ago. This twelve lead ECG was taken in the coronary care unit.

Questions:

1. The twelve lead ECG shows:
 a. Short bursts of ventricular tachycardia.
 b. An acute anteroseptal myocardial infarction.
 c. Left axis deviation compatible with left anterior hemiblock.
 d. Frequent premature ventricular beats.
 e. Left ventricular hypertrophy.

2. The following statement(s) is/are true.
 a. A temporary demand pacemaker is indicated here.
 b. Congestive heart failure but not cardiogenic shock is present in this patient.
 c. A coronary arteriogram would be helpful here.
 d. Careful consideration of anti-arrhythmic drug therapy will be needed.
 e. All of the above.

(Continued on page 435)

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Endauralagy and Ureterascapy: Triumphs and Pitfalls
August 3-4
Specialty Review in Internal Medicine, Certifying
August 5-11
Specialty Review in General Surgery, Part II
August 20-31
Fiberaptic Calanascapy
August 22-24
Fiberaptic Esaphagagastric Endascapy
August 27-29
Current Clinical Neuralagy: A Camprehensive Review
September 17-21
Specialty Review in Dermatalagy
September 17-21
Specialty Review in General Surgery, Part I
September 17-28
Fiberaptic Calanascapy
September 19-21
Pediatric Neuralagy
September 24-26
Fiberaptic Esaphagagastric Endascapy
September 24-26
Specialty Review in Nephralagy
September 30-October 4
Specialty Review in Hematalagy
September 30-October 4
Psychiatry: An In-Depth Review af Cantemparary Practice
October 8-12
Specialty Review in Vascular Surgery
October 15-19
Specialty Review in Infectiaus Disease
October 15-19
Specialty Review in Rheumatalagy
October 15-19
Specialty Review in Pulmanary Disease
October 22-26
Specialty Review in Obstretrics and Gynecalagy: Practical Aspects
October 29-November 3

For further information, write:
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School of Medicine
707 South Wood Street
Chicago, IL 60612
or call toll-free at
800-621-4651
in Illinois call
800-621-4649.

A Delicate Balance

ISMS Guide To Hospital Medical Staff Bylaws

At its September, 1983, meeting the ISMS Board of Trustees approved and mandated publication of the "ISMS Guide to Hospital Medical Staff Bylaws."

This document was developed by the Ad Hoc Committee on Resolution 37 (A-81), a subcommittee of the Council on Medical Services Members of that subcommittee, chaired by Wallace Berkowitz, M.D., were James R. DeBord, M.D., C. Larkin Flanagan, M.D., Allan L. Goslin, M.D., A. Beaumont Johnson, M.D., Donal D. O'Sullivan, M.D. and David Whitney, M.D.

It is hoped that this guide will help physicians to balance the many complex issues confronting hospital medical staff members. As demonstrated at the November, 1983, ISMS Leadership Conference, today's physician must juggle many roles. This guide is intended to assist the physician who seeks to meet his responsibilities and exercise his rights in the professional context.

This is the third and final section of a series begun with the April, 1984, issue. Next month, IMJ *will feature the first section of the appendix to this document, "Legal Considerations of Medical Staff Bylaws."*

ARTICLE VIII. DEPARTMENTS OF THE MEDICAL STAFF

Medical Staff Departments will be tailored to the Hospital's changing needs. Each Department shall develop its own Rules and Regulations, which shall become effective upon approval by the Medical Executive Committee. These Rules and Regulations are to be periodically reviewed and amended as appropriate.

ILLINOIS REQUIREMENTS

The bylaws are to provide for such departments and divisions as are warranted (3-1.1.d.).

JCAH RECOMMENDATIONS

The bylaws are to provide for the organizational structure of the Medical Staff, including departmentalization or nondepartmentalization, in accordance with the size of the Hospital and scope of Staff activities.

A JCAH monograph suggests that the Staff should consider the need for departments by reviewing the size of the Active Staff, the number of patients treated by each specialty member and the need for more efficient administration of the Staff's responsibilities.

If departments are approved, the bylaws should specify all departments and/or services, their responsibilities,

frequency of meetings, and mechanism for creating new departments or subsections. Each member should be assigned to at least one department. The bylaws should provide for review of patient services provided by department members.

Section A. Requirements for Section or Subsection Status of a Medical Staff Department

In order to be eligible for recognition as a section or subsection of a Medical Staff Department, the following criteria must be met:

1. There must be a definable and/or certifiable specialty with at least five Active Staff members;

2. There must be a written set of Rules and Regulations;

3. The proposed section must be able and prepared to delineate privileges for its members; and

4. The section must have at least ____ meetings yearly to review clinical performance of its members, patient care review and general department business, including ratification of previous actions by its department's executive committee.

A quorum for a section meeting should be at least three members. The Chief of the section shall be elected and subject to recall by a majority of the section voting.

Section B. Organization of Departments

1. Election and Recall of Officers

A regularly scheduled meeting of each Department shall be held annually, prior to the last general staff meeting of the Medical Staff year, to elect a Chief and Vice-Chief for the Department. Each officer shall be elected by a majority of the Active members voting. Officers shall be elected for a ____ year term. No officer may serve more than ____ consecutive terms.

Each officer may be recalled by a majority of the Active members voting at a regular or specially called meeting of the Department. A recall requires a request for such action by ten percent of the Department's Active members. Recall votes shall be held and voted on at the next regularly scheduled meeting of the Department following an approved recall.

2. Department Functions

The Department Chief shall have responsibility for all functions, services and practitioners assigned to that department, including the guidance of Provisional Staff members assigned to the Department.

The Vice-Chief shall act in all matters in the absence of the Department Chief, with all the powers of that office.

The Department functions shall include, but not be limited to the following:

1. To evaluate the professional performance of members who exercise privileges in the Department and utilize this evaluation in recommending reappointment;

2. To recommend to the Medical Executive Committee privileges to be granted current and prospective members;

3. To conduct medical care evaluations; and

4. To report to the Medical Executive Committee any actions recommended.

A Department shall, by election or appointment by its Chief, provide a sufficient number of Active Department members to act on the Standing Committees. Ordinarily, no person should represent a Department on more than one committee, except the Department Chief, who shall be a voting member of the Medical Executive Committee. The Department Vice-Chief may vote on the Medical Executive Committee in the absence of the Department Chief.

3. Department Executive Committee

Committee representatives and the elected Chiefs of the sections of the Department, shall constitute the Executive Committee of a Department. The Executive Committee shall act for the Department between Department meetings. All Executive Committee actions shall be subject to ratification by a majority of the Active members of the Department voting at the next Department meeting. A Department Executive Committee should meet ____ times a year to perform routine administrative functions and peer review.

The Department Chief shall act for the Department between meetings of the Department Executive Committee. The Executive Committee shall have the power to overturn a decision or action of the Department Chief by conducting a vote supported by a majority of the Executive Committee members present at a meeting.

4. Actions of Department

Any action of a Department Executive Committee can be overturned by a majority of the Active Department members voting at a duly constituted Department meeting.

No Department action will be valid unless ratified by the Medical Executive Committee. If the Medical Executive Committee disapproves of a Department's action, a majority vote of the Active members of the entire Medical Staff, at its next meeting, shall resolve the conflict between the Department and the Medical Executive Committee.

Notice of actions to be taken on behalf of a Department shall be sent in advance to all department members with adequate information to allow for understanding and debate of the issues. Actions shall be ratified by a majority of the active members in the Department who are present and voting.

All Department members may discuss issues, but only Active and Associate members shall have the power to vote. The Department Chief shall vote only to make or break a tie.

GENERAL COMMENTS

In voting for a tie, the Department Chief can postpone a close action which may split the department into factions. The postponement should lead to a further discussion and concensus on the issue at hand.

ARTICLE IX. MEDICAL STAFF OFFICERS

Section A. Officers and Qualifications

Officers of the Medical Staff shall be elected by the Staff and shall include Chief of Staff, Vice-Chief of Staff, Secretary and Treasurer. Each officer shall be an Active Staff member possessing adequate ability and experience in Medical Staff activities and who has expressed a willingness to devote the necessary time to the responsibilities of the office to which he is elected. An officer must have been a member of the Active Staff for ____ years prior to his election, and must remain a member in good standing of the Active Staff during his term of office.

ILLINOIS REQUIREMENTS

The bylaws are to provide for such officers as are warranted (3-1.1.e).

The Medical Staff is responsible for the election of its officers or for recommendations to the Governing Body for appointment of the officers (3-1.2.b).

JCAH RECOMMENDATIONS

The bylaws should provide for the selection, qualifications, responsibilities and terms of office of Staff members and department/service Chairmen.

1. Chief of Staff

The Chief of Staff shall serve as the principle elected officer of the Staff to:

a. Act in coordination and cooperation with the Administrator in all matters of mutual concern within the Hospital;
b. Call, to preside at, and to be responsible for the agenda of all meetings of the MEC and the General Staff;
c. Serve as Chairman of the Medical Executive Committee;
d. Serve as a member of the Joint Conference Committee;
e. Serve as ex-officio member of all other staff committees without vote;
f. Be responsible, through the MEC, for the enforcement of Staff Bylaws, Rules and Regulations, the implementation of sanctions where these are indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
g. Be responsible for appointing committee chairmen and committee members to all standing and special committees, except the Medical Executive Committee;
h. Present the views, policies, needs and grievances of the Staff to the Administrator and directly to the Governing Board;
i. Receive and report the policies of the Governing Board to the Staff;
j. Report to the Administrator and Governing Board on the performance and maintenance of quality by the Staff; and
k. Be the principal spokesman for the Staff.

2. Vice Chief

In the absence of the Chief of Staff, the Vice Chief shall assume all the duties and has the authority to act in all matters for the Chief of Staff. He shall be a member of the Medical Executive Committee. He shall perform such additional duties as may be assigned to him by the Chief of Staff or the MEC. He shall automatically succeed the Chief when the latter fails to serve for any reason.

3. Secretary

The elected Secretary shall ensure that minutes are kept of all meetings of the Staff, Medical Executive Committee, standing committees, special meetings and other appropriate sessions. He shall attend to correspondence and any other duties of the office as needed, including being a member of the MEC.

The elected Secretary shall see that the Staff is kept current on all actions of the Medical Executive Committee and will notify members at least two weeks in advance of upcoming meetings and issues. The elected Secretary shall also see that Medical Staff records and correspondence are securely kept in Medical Staff facilities and secure pledges of confidentiality from any and all persons acting as staff agents, including such hospital employees as have occasion to function in Medical Staff affairs.

ILLINOIS REQUIREMENTS

The bylaws are to provide for written minutes to be kept of all meetings (3-1.1.h).

4. Treasurer

The Treasurer shall be responsible and accountable for maintaining the financial records and funds of the Medical Staff. The bank to be used shall be determined by the Medical Executive Committee. All withdrawals shall require the signature of two of the four elected Staff officers. A treasury report shall be made at each Medical Executive Committee meeting and general Staff meeting. He is a member of the MEC.

Section B. Election Process

Candidates for office shall be nominated at the last Staff meeting of each fiscal year of the Staff and be elected for a ____ year term by written secret ballot by a majority of the Active Staff voting. If no majority is obtained on the first ballot, a runoff between the two top contenders shall be held.

A nominating committee of the three most recent past Chiefs of Staff, plus two Active members from the Staff at large, shall select nominees for each office. There will be opportunity for nominations from the floor, by Active members, at the Staff meeting where elections are held.

No officer shall serve two consecutive terms in the same office.

Section C. Recall Process

An officer of the Medical Staff may be recalled by a majority of the Active staff members voting, if a recall is requested by 10% of the Active Staff. The determining vote will be held at the next regular Staff meeting following the Staff meeting at which the petition of the 10% of the Staff is presented, or at a special meeting of the Staff convened not less than 30 days after the meeting at which the petition is offered.

If the Chief of Staff is recalled, the Vice-Chief shall become the Chief of Staff and a new Vice-Chief will be elected.

Section D. Vacancies in Office

Should any Medical Staff officer, with the exception of the Chief, be unable to serve, the office shall be filled by the MEC until the next regular meeting of the Staff when a special election shall be held to elect a new officer for the remainder of the term. The Vice Chief will automatically assume the office of Chief, to serve out the Chief's term of office.

ARTICLE X. MEDICAL STAFF COMMITTEES

The MEC shall decide the number and functions of Staff committees necessary to meet the responsibilities and purposes of the Staff.

ILLINOIS REQUIREMENTS

The bylaws are to provide for committees as are warranted to assure the responsibility for such functions as pharmacy and therapeutics, infection control, utilization review, patient care evaluation and the maintenance of complete medical records (3-1.1.f).

The Medical Staff is responsible for providing recommendations to the Governing Body regarding organization of the staff, and appointments and privileges of staff members and applicants (3-1.2.b).

The Staff is responsible for making recommendations to the Governing Body regarding matters within the purview of the Medical Staff (3-1.2.c).

The bylaws are to provide for review and analysis of the clinical experience of the hospital at regular intervals—the medical records of patients to be the basis for the review (3-1.1.i).

LEGAL CONSIDERATIONS

Chapter V (p. 13-15)

JCAH RECOMMENDATIONS

A JCAH monograph suggests that when bylaws provide for the designation of committees and/or functions their responsibilities, composition and interval of meeting should be stated.

ISMS POLICY

A hospital's Medical Staff should be an autonomous, self-governing body whose members participate in the activities of Medical Staff and Hospital committees. However, physicians should distinguish between committees where the Hospital gives the Staff authority and responsibility and those where the Hospital has full responsibility. Medical Staff committees should be those composed solely of members of the Medical Staff and concerned with the quality of medical care. Hospital committees should be viewed as those created for some general hospital function and composed mainly of hospital personnel, that may or may not include Medical Staff members.

GENERAL COMMENTS

The Illinois Hospital Licensing Act regulations and the JCAH Standards require a Medical Staff to be responsible for or to participate in a number of functions and activities. Theoretically, the vast majority of these functions and activities can be accomplished through one committee, the MEC, with individual Staff members assigned certain responsibilities.

However, the following hospital committees are *required* to have physician representation, as appropriate: Infection Control, Pharmacy and Therapeutics, Safety and Sanitation, Home Health Advisory Committee, Institutional Review Board and Radiation Safety.

Section A. Medical Executive Committee

The MEC is empowered to act for the Staff in the intervals between Staff meetings.

1. Composition

Voting members of the Medical Executive Committee shall include the Chief of Staff, who shall vote only to break a tie; the Vice-Chief of Staff; the Secretary; the Treasurer; the immediate past Chief of Staff (if not recalled); the Chiefs of each Department or Department groups; and any other Medical Staff members deemed appropriate and elected by its general Medical Staff.

GENERAL COMMENTS

The provision allows the Medical Staff as a whole to determine the final composition of the MEC and prevent the loading of this Committee with staff members in a salaried or other contractual relationship with the Hospital, who may or may not be representative of the staff's interests.

If a hospital has many departments, these may be placed in logical groupings, with a representative of each grouping placed on the MEC.

All members of the Medical Staff are eligible for membership on the governing executive committee, but a majority of the Committee's members must be physicians holding Active Staff status.

JCAH RECOMMENDATION

All members of the medical staff are eligible for membership on the executive committee, but a majority of executive committee members are fully licensed physician members of the medical staff actively practicing in the hospital.

2. Meetings

During meetings of the Medical Executive Committee, representatives of various Staff committees may be asked to present reports. A Committee representative shall have the opportunity to participate in any discussion regarding his committee items, but may not vote on the item(s) nor stay for the remainder of the meeting unless specifically requested by the Chief of Staff with the concurrence of a majority of the voting members of the Medical Executive Committee.

The Medical Executive Committee may invite appropriate members of the Medical Staff, the Administrator or other Hospital representatives or employees as resource people to comment, without a vote, on specific problems or issues.

GENERAL COMMENTS

This clause is designed to preclude dominance of the MEC by the Hospital Administration.

The Medical Executive Committee will not be considered in session if non-invited persons are in attendance; or persons invited remain in the meeting room after the purpose for which they were invited is completed.

A secretary employed by the Medical Staff may attend meetings at the discretion of the Medical Executive Committee, to take notes and to perform other appropriate secretarial duties.

GENERAL COMMENTS

Staff should hire and train their own Medical Staff Secretary/Coordinator to ensure that person's loyalty and the confidentiality of Staff information. Certification and courses for Medical Staff Coordinators are available through their own professional association.

Section 3. Duties of the Medical Executive Committee

GENERAL COMMENTS

This list of MEC duties is not necessarily exhaustive—*However*, adding other duties should be done ONLY after examination of the proposed addition from the standpoint of the *proper* function of the Medical Staff, to wit, the CONTROL OF THE QUALITY OF MEDICAL CARE IN THE HOSPITAL.

JCAH RECOMMENDATIONS

The executive committee is responsible for making recommendations directly to the governing body for its approval. Such recommendations pertain to at least the following:

1. The structure of the medical staff;
2. The mechanism to review credentials and to delineate individual clinical privileges;
3. Recommendations of individuals for staff membership;
4. Recommendations for delineated clinical privileges for each eligible individual;
5. The organization of the quality assurance activities of the staff, as well as the mechanism used to conduct, evaluate and revise such activities;
6. The mechanism by which membership on the medical staff may be terminated; and
7. The mechanism for fair hearing procedures.

The following duties are the responsibilities of the Medical Executive Committee:

a. To receive and act upon reports and recommendations of Medical Staff Committees and Departments;

b. To implement approved policies of the Medical Staff;

c. To recommend to the Governing Board all matters relating to appointments and reappointments, staff categorization and clinical privileges;

d. To initiate, investigate, monitor and pursue corrective action involving Staff members;

e. To cooperate in obtaining and maintaining accreditation;

f. To comment on the quality of care provided by the Medical Staff and employees of the Hospital in periodic reports to the Governing Board;

g. To ratify or reject the creation and membership of special and/or ad hoc committees with specific powers and charges to handle delegated problems;

h. To act on behalf of the Medical Staff and serve as a liaison between the Medical Staff and the Governing Board and its representatives;

i. To fulfill all functions required by the State, Federal and accrediting bodies;

j. To act in the absence of a Departmental structure to perform the functions of a Department as specified in the bylaws;

k. To determine what the yearly dues for staff members shall be and make appropriate levels for different staff categories; and

l. To levy assessments on any and all Staff members as determined as necessary to discharge Staff responsibilities, including the cost of legal advice and representation from independent Medical Staff counsel.

ISMS POLICY

Medical Staffs are reminded that hospitals do not have the privilege or right to make compulsory assessments on individual members of the Medical Staff for building funds or other Hospital programs, nor to demand an audit of Staff members' personal financial records as a requisite for Staff appointment.

GENERAL COMMENTS

Since the legal relations of the Medical Staff are becoming increasingly complex, it may be necessary for the Medical Staff to acquire the aid of legal counsel distinct from the Hospital Counsel. This clause permits the Medical Staff to do so.

4. Meetings and Actions

The MEC shall meet as often as necessary, but at least ten times per year. Fifty percent of the MEC members being present shall constitute a quorum.

Any action of the MEC can be overturned and nullified at the next regularly scheduled Staff meeting, if a majority of the Active Staff present vote to do so.

GENERAL COMMENTS

This provision prevents domination of the Medical Staff by the MEC and further helps to prevent arbitrary or capricious actions taken without necessary debate. Medical staff power rests with the Active Staff, not the MEC.

All actions of the MEC, duly reported and not overturned, shall be forwarded to the Governing Board for approval or information.

Final determinations on all apointment, reappointment, disciplinary and administrative matters shall be made by the Governing Board.

If the Governing Board does not challenge an MEC action, the decision of the MEC shall be considered final.

GENERAL COMMENTS

This provision is consistent with general practice, recent explicit court decisions in other states, and a trend that is perceptible nationwide.

Section B. Joint Conference Committee

The Joint Conference Committee will consist of an equal number of Medical Executive Committee and Governing Board representatives and be chaired by the Chief of Staff or his designee. It should discuss mutual problems as they occur. It will meet quarterly or more often as needed. A quorum will consist of 50% of the assigned committee members present and the Chairman but in no case less than three persons.

An action by the Governing Board contrary to a Medical Executive Committee recommendation of action will cause a review by the Joint Conference Committee within 30 days.

Any differences remaining will be submitted to binding arbitration by a three person panel. One representative shall be selected by the Medical Executive Committee, one by the Governing Board and a third selected by these two representatives of those bodies.

GENERAL COMMENTS

When a joint conference committee exists, the Medical Staff must select its representatives to this committee.

Section C. Hospital Committees

Staff members may be appointed by the Chief of Staff to serve as consultants, advisors or members of Hospital committees, when requested by the Governing Board or its representatives.

Hospital committees are those bodies consisting of Medical Staff and non-Medical Staff members each of whom have voting privileges. Functions dealt with by Hospital Committees include, but are not limited to: pharmacy and therapeutics; infection control; utilization review; patient care evaluation; and medical records.

ILLINOIS REQUIREMENTS

The bylaws must provide for such functions as pharmacy and therapeutics, infection control, utilization review, patient care evaluation, and maintenance of complete medical records (3-1.1.f).

ISMS POLICY

Physicians on a hospital Medical Staff should encourage and cooperate in efforts to see that hospital care is delivered in the most cost effective manner, without compromising quality.

JCAH RECOMMENDATIONS

Representatives of the Medical Staff should participate in any hospital deliberations that affect the discharge of medical staff responsibilities.

Section D. Committees of the Medical Staff

Standing Committees other than the MEC, will include, but not be limited to the following: Credentials Committee, Bylaws Committee, ____, ____, and ____.

Members and Chairmen of Committees, with the exception of the MEC, shall be appointed by the Chief of Staff to insure broad representation, as appropriate on each committee, of Department representatives. Membership shall be in staggered two year terms to allow for continuity of activity.

If the total number of Medical Staff members becomes insufficient to support the listed committees, the Medical Executive Committee may combine functions in fewer committees or assume the responsibility of any or all of the specified committees itself.

All Committees shall keep minutes and report to the Medical Executive Committee at its regularly scheduled meetings.

JCAH RECOMMENDATIONS

A JCAH monograph suggests that the bylaws should specify how the Staff will carry out its functions through committees; for each committee, the bylaws should state its purpose, responsibilities, size, composition, method of member selection, frequency of meetings and reporting requirements.

1. Credentials Committee

This committee shall be composed of ____ members and shall meet ____ to investigate the credentials and qualifications of all applicants for initial membership or reappointment for subsequent report to the Medical Executive Committee. It shall also investigate, review and report on matters referred to it by the Medical Executive Committee.

2. Bylaws Committee

The Bylaws Committee shall have ____ members and will meet at least annually, or more often as necessary to develop, review and make recommendations regarding the Medical Staff Bylaws, rules and regulations, as indicated by changing legal, social, clinical, hospital or community needs.

3. _____ Committee

The ____ committee shall have ____ members and meet ____ times a year to ____.

ISMS POLICY

Medical staffs and ISMS should clearly designate and distinguish in their bylaws and committee names, "cost containment" activities and "quality assurance" activities so that more clarity is brought to the developing conflicts between cost and quality.

4. Ad Hoc Committees

Ad Hoc Committees will be created or activated as deemed necessary by the Chief of Staff, to perform special functions.

GENERAL COMMENTS

A Committee for Impaired Physicians may be a standing or an ad hoc body of the Medical Staff. For a detailed look at how such a committee functions, write to ISMS for its publication, "Guidelines for Hospital Committees to Assist Impaired Physicians."

ISMS POLICY

County medical societies are encouraged to form standing committees composed of medical society officers and representatives of all hospital staffs in their area to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations and official and voluntary health agencies in their community.

ARTICLE XI. MEDICAL STAFF MEETINGS

Section A. Annual Election Meeting

The annual election meeting shall be the last meeting held before the end of the Medical Staff year.

Summation reports from officers and Department chiefs may be presented. Officers and members-at-large of the Medical Executive Committee shall be elected.

Written ballots will be used.

The Department Chiefs and Department executive committee members who were elected at their last Department meeting will be acknowledged.

Section B. Regular Meetings

Regular Staff meetings should be held ____, at which time Department actions can be reviewed and actions of the Medical Executive Committee ratified. These meetings may cover administrative, clinical, professional or community topics of interest to the Staff.

All members may speak to issues, but only Active Staff members may vote at the General Medical Staff meetings.

The elected Staff Secretary will see that sufficient advance notice and background materials are sent to members to permit meaningful discussions. Such materials can be provided through the usual Medical Staff communication mechanisms.

GENERAL COMMENTS

This provision would prevent the intentional or unintentional presentation of written materials and/or proposals requiring the voting endorsement of the Staff without providing adequate time for the members to review and analyze the nature of the provisions to be adopted.

A similar procedure is recommended for Committee meetings.

ILLINOIS REQUIREMENTS

The bylaws are to provide that active Medical Staff meetings be held regularly and that written minutes of all meetings be kept (3-1.1.h.).

Notice of meetings shall be sent to the office address of each member as listed in the Medical Staff records. Minutes of previous meetings requiring approval should be sent in the same manner and with the notice of the next meeting.

Section C. Special Staff Meetings

Special Staff meetings may be called by the Chief of Staff independently or upon request of the Governing Board, the Medical Executive Committee or by agreement of 10% of the Active Staff. No business shall be transacted at any Special Meeting except that stated in the request and the notice.

Notice should be mailed at least ten days prior to the meeting. Notices should also be posted in the Hospital, where the Staff would normally see them. If printed material is sent supporting one side of an issue, the opposing side should be given equal opportunity to inform the members of the staff of its point of view.

Section D. Quorum and Voting Requirements

1. Staff Meetings

One-quarter of the total Active Staff shall constitute a quorum at any regular or special Staff meeting. If a quorum cannot be obtained at the scheduled time and place, the issues may be debated and a mailed vote may be obtained. The majority vote of the Active members voting shall control on all issues but changes in the Bylaws. Two-thirds majority of the Active Staff members voting shall be required to adopt Bylaws amendments or revisions.

GENERAL COMMENTS

This provision is designed to expedite staff business in a manner that does not place an onerous burden on Staff members.

2. Department Meetings.

Similar quorum, special meeting, notice and voting requirements shall apply to medical Department meetings.

Section E. Attendance Requirements

All Staff members are encouraged to attend medical Depart-

ment and Staff regular and special meetings. Absence without excuse for more than 75% of the yearly total of these meetings may be cause for reduction in Staff category.

GENERAL COMMENTS

While all Staff members should fulfill their meeting responsibilities, attendance requirements must be reasonable and not coercive.

JCAH RECOMMENDATIONS

The bylaws are to create requirements regarding the frequency of and attendance at general Staff and department/service meetings of the Medical Staff.

1. Special Attendance

When a Medical Staff Department or Committee requires a member's presence to discuss professional or ethical performance, the member is expected to attend unless excused by the Chief of Staff for good cause.

If the member fails to appear, the meeting will proceed, resolve the issue and transmit a record of the findings, along with any recommended corrective action to the Medical Executive Committee, and simultaneously to the member who was the subject of discussion.

Section F. Secret Vote

A secret ballot vote shall be held if requested by any member entitled to vote at any regular or special meeting of the Staff, Department or medical committee.

ARTICLE XII. DUES

Dues will be $\$___$ per year for Active Staff members (and $\$___$ for each of the other Staff categories specified), or such as the Medical Executive Committee decides.

Medical Staff funds will be segregated from all other funds—invested for interest in a prudent manner, utilized to discharge such Medical Staff financial obligations as the Medical Executive Committee finds appropriate and for no purpose other than Medical Staff affairs.

GENERAL COMMENTS

This provision lodges control of the funds in the Medical Staff and prevents commingling of such funds with Hospital funds.

ARTICLE XIII. RULES AND REGULATIONS

The Medical Staff will adopt such rules and regulations as may be necessary for the proper conduct of its work, including, but not limited to, conditions or situations requiring consultation, identifying when an assistant is needed in surgery, physician employees credentialed by the Medical Staff, tissue analysis and other functions which may arise or be required to comply with state law, JCAH Standards or professional standards.

ILLINOIS REQUIREMENTS

The Medical Staff shall be organized in accordance with written bylaws, rules and regulations, approved by the Governing Body (3-1.1).

The bylaws must provide for such functions as pharmacy and therapeutics, infection control, utilization review, patient care evaluation and maintenance of complete medical records (3-1.1.f).

The bylaws, rules and regulations are to provide for review and analysis of the clinical experience of the hospital at regular intervals, using the medical records for the review (3-1.1.i); and for Medical Care Evaluation studies (3-1.1.0).

The bylaws, rules and regulations must provide for conditions or situations which require consultation (3-1.1.j) and for consultation between Medical Staff members in complicated cases (3-1.1.k).

The bylaws, rules and regulations must provide that tissue removed at an operation shall be examined by a qualified pathologist and that the findings shall be made a part of the patient's medical records (3-1.1.l).

The rules and regulations must provide for keeping complete medical records (3-1.1.m).

The rules and regulations must provide for a written utilization review plan which shall be in accordance with the Conditions of Participation for Hospitals in the Medicare Program (3-1.1.n).

The rules and regulations must provide for a physician as first assistant to major and/or hazardous surgery. Written criteria to determine when an assistant is necessary shall be established and be part of the surgical department procedure manual. The rules must also insure that a qualified surgical assistant whether a physician or non-physician, assists the operating surgeon in the operating room (3-1.1.p).

The bylaws, rules and regulations must provide for determining what additional privileges may be granted a Staff member for the use of his/her employed licensed Physician's Assistant in the hospital, in accordance with the policies and procedures recommended by the Medical Staff and approved by the Governing Body (3-1.1.q).

Staff requesting this additional privilege shall submit for review and approval of the Medical Staff and the Governing Body: (a) the curriculum vitae of the identified Physician's Assistant, and (b) written protocol with the description of duties, assignments and/or functions and including description of the manner of performance with the hospital by the Physician's Assistant in relationship with other hospital staff (3-1.1.q).

The Medical Staff is responsible for the adoption of rules and regulations for its government (3-1.2.b).

The rules are to stipulate that all persons admitted to the Hospital shall be under the supervision of a member of the Medical Staff. Patients admitted by a podiatrist or dentist shall be under the care of both the admitting Staff member and a physician member of the Staff. The podiatrist or dentist is responsible for all care within the limits of the privileges granted to him, while the physician is responsible for all aspects of the patient's medical care.

The rules shall provide that no medication or treatment shall be administered to a patient except on the written order of a member of the Medical Staff. Verbal orders shall be used only in emergency situations and are to be signed before the member of the Medical Staff leaves the area. Telephone orders shall be used sparingly and countersigned within 24 hours (3-3.1).

Members of the Medical Staff shall give orders for medication and treatment only to the licensed, registered or certified professional persons in the course of practicing their identified specific discipline, such as registered professional nurse, registered dietitian, registered pharmacist, registered or certified respiratory therapist, registered physical therapist and registered occupational therapist (3-3.b).

The rules shall provide for the medical directors of the laboratory or other diagnostic services to respectively authorize the performance of diagnostic tests and procedures at the request of other than members of the Medical Staff in accordance with policies approved by the Medical Staff and the Governing Body (3-3.c).

The Governing Body shall provide that one or more physicians shall be available at all times for emergencies (3-4).

JCAH RECOMMENDATIONS

When there is a medical staff policy that permits patient care orders to be written by the house staff, the policy must not be extended to prohibit orders from being written by the patient's private physician or dentist without his agreement. Further, the staff member's declination to participate in this practice shall not in itself be a basis for sanctions relating to staff membership or the holding of clinical privileges, or to the loss of other medical staff prerogatives. This principle should be made clear in the medical staff bylaws, rules and regulations.

The Staff rules and regulations shall specifically relate to the role of the Medical Staff in the care of inpatients, ambulatory care patients, emergency patients and home care patients. The rules may be general in nature, applicable to the whole staff or may be department/service specific. The mechanism for providing emergency care is to be defined. The rules and regulations of department/services shall not conflict with each other, the bylaws and rules of the Staff or with the bylaws of the Governing Body.

ARTICLE XIV. AMENDMENTS TO THE BYLAWS

Amendments to these bylaws may be made by giving notice in writing of such amendment at a regular or special meeting of the Medical Staff. Such proposals will be referred to the Bylaws Committee, which will report in writing at the next regularly scheduled meeting, stating clearly what conclusion it reached and the reasons therefor. Notice of the amendments shall be sent along with copies of the changes, to each Staff member, 30 days prior to the meeting at which the amendments shall be considered.

An amendment will require two-thirds majority of the Active members present and voting for adoption providing a quorum is present. Such an amendment will become effective on approval by the Governing Body.

JCAH RECOMMENDATIONS

The bylaws are to include a mechanism for adopting, amending, repealing or otherwise revising the Medical Staff bylaws, rules and regulations. The bylaws, rules and regulations are to be reviewed annually and revised as necessary, or according to a frequency specified in the bylaws.

GENERAL COMMENTS

When necessary, the bylaws, rules and regulations, should be revised to reflect changes in staff practices, organization, change in membership and functions. The bylaws should specify the vote required for amendment.

ARTICLE XV. ADOPTION

These bylaws, rules and regulations shall be adopted consistent with any existing bylaws of this organization, or by a simple majority vote of the Active members of the Staff at any regular Staff meeting, as is appropriate to the nature and any existing Bylaws of the Medical Staff of _____ Hospital.

These Bylaws will become effective on approval by the Governing Body. When adopted and approved, they will be equally binding on the Governing Body and the Medical Staff, and will replace previous bylaws, rules and regulations wherever situated.

JCAH RECOMMENDATIONS

Staff bylaws, rules and regulations are subject to the approval of the Governing Body. This approval shall not be unreasonably withheld.

Acknowledgement

The Committee acknowledges the help of many individuals, including ISMS staff, who gave freely of their time and experience. Particular note must be given to the Los Angeles County Medical Society, whose draft Model Hospital Medical Staff Bylaws was often consulted during the initial work of the Committee.

Editor's Note:

This concludes the ISMS Guide to Medical Staff Bylaws. Next month, the series will proceed to the appendix for this document "Legal Considerations of Medical Staff Bylaws." On conclusion, copies of the complete document and appendix will be available upon request from the ISMS headquarters office.

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Diplomate American Board of Radiology

MARK GREENBERG, M.D.
Diplomate American Board of Radiology

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The population has increasingly been exposed to various drugs. A study in the outpatient use of prescription drugs has shown the most frequently prescribed drugs in the therapeutics classes to be (in decreasing order) anti-infectives, cardiovasculars, psychotherapeutics, diuretics, cold drugs, hormones, antiarthritics, contraceptives, antispasmodics, bronchial therapeutics, dermatologicals, sedatives, nutrients and supplements, diabetic therapeutics, ophthalmics, vitamins and thyroid drugs. The largest volume of prescription drugs (in decreasing order) were hydrochlorothiazide, codeine, combination oral contraceptives, erythromycin, propanolol, diazepam, triamterene, digoxin, furosemide, atropine, potassium, theophylline, phenobarbital, penicillin and amoxicillin (Baum, C. *et al: JAMA* 251:10, 1923-7, March 9, 1984)

Forty patients with chronic pain were evaluated by therapists and by patients as to pain alleviation. In only 25 instances did therapists and patients concur as to failure or relief. Generally the therapists were more optimistic in assessment of success than the patients. Both groups indicated that pain alleviation was associated with less anxiety, depression or hostility. The authors stated that psychological intervention is an important factor in recovery. (Daniel, M.J.: *Nerv Ment Dis.* 171:729-33, 1983)

A random sample study of 295 rheumatoid arthritis patients showed that 13.2% had a first/or second degree relative with type I diabetes. Only 3.8% of a random sample 307 patients with degenerative arthritis had similarly afflicted relatives. Autoimmune thyroid disease was noted in 13% of relatives with rheumatoid arthritis and in only 6% within the degenerative arthritis group. (Thomas, J.B.: *Ann Rheum Dis* 42:297-300, 1983)

A prospective study was made of 107 elderly outpatients with dementia. Diagnoses were based on history, physical and mental status examinations. Objective improvement occurred in 25 patients after treating unrecognized coexisting medical and psychiatric diseases or stopping unnecessary medications. Distinguishing characteristics of reversible dementia included shorter duration, use of more prescriptions and less severity. Careful clinical observation is significant in such cases, and extensive testing less necessary. (Larsen, E. B. *et al.: Ann Intern Med.* 100:3, 417-23, March 1984)

Some of the variables in predicting post-hospital survival for myocardial infarction were analyzed in 818 outpatients. Cardiac mortality during the first year after discharge was 11.1% with five important factors obtained from the history and the first 24 hours of hospitalization. These were: maximal level of blood urea nitrogen, previous myocardial infarction, displaced left ventricular apex and sinus bradycardia. At discharge these patients frequently exhibited an S3 gallop. Addition of more information did not improve the predictability. (Madsen, E. B. *et al: Am J Cardiol* 53:47-54, 1984)

Results of a recent study support percutaneous transluminal angioplasty for patients with peripheral vascular disease, and surgical intervention if this fails. It is estimated that this order in the procedures would save 352 lives, $82 million and 5,006 patient limbs. These conclusions are based on a review of the literature on experience with iliac and femoral angioplasty and surgery between the years 1970-1981. (Doubilet, P., Abrams H. L.: *N. Engl. J. Med* 310:2, 95-102, 1984)

Metoprolol tartrate and propranolol hydrochloride were assessed in patients with essential tremor. Efficacy was evaluated by the patient, clinical scoring, and tremorgrams. Ten of 20 patients were improved with propranolol and 13 of 23 patients improved on metoprolol (including three patients with asthma whose respiratory distress increased on propranolol). Age, duration of tremor, tremor frequency, family history, or response to intravenous ethyl alcohol did not distinguish responders from nonresponders. (Koller, W.C., Biary N.: *Arch Neurol* 41:171-2, Feb. 1984)

Nearly one percent of live-born infants are infected with human cytomegalovirus. Nearly 60-80% of U.S. inhabitants acquire this infection by mid-adulthood. The majority of congenitally infected infants do not develop nervous system damage, but microcephaly, psychomotor retardation, seizures and deafness can occur. About 10% of asymptomatic congenitally infected infants develop sensorineural hearing loss. Nearly 7000 persons in the U S each year have neurologic disorders attributable to cytomegalovirus. (Bale, J. F.: *Arch Neurol* 41:310-20, March 1984)

Nephrotoxicity was evaluated in two prospective randomized clinical trials of 214 patients with gentamicin and tobramycin. Nephrotoxicity was defined as 50% or greater fall in the calculated creatinine clearance. Patients had nephrotoxicity in 14.1% of cases, had a higher initial creatinine clearance, were more often women, and were more likely to have liver disease. Factors that did not add to the risk were diabetes, dehydration, serum bicarbonate, bacteremia, urinary tract infections, gentamicin or tobramycin use, duration of therapy, total aminoglycoside dose or use of clindamycine, furosemide, or cephalothin. (Moore, R.D., *et al: Ann Intern Med.* 100:3, 352-7, March 1984)

Post-stroke depression is noted in about 50% of patients, often severe and longstanding. In this study, depression was studied by means of the Hamilton depression scale, Zung depression scale, present state examination and an overall depression scale. Of 39 cases, five dropped out, one patient on placebo developed mania, one patient on placebo refused to be interviewed, one patient on nortriptyline complained of dizziness, one became delirious and one complained of oversedation. The initial improvement noted in the placebo group waned after the third week when it was surpassed by the nortriptyline group. The medicated group showed significant improvement, especially in cognitive and physical capacities. (Lipse, J. R., *et al: The Lancet,* 8372:297-300, Feb 11, 1984)

The authors reviewed 1669 patients who had coronary bypass surgery between 1969 and 1981 to determine the neurologic complications. Cerebral complications were noted in 3.8%, altered mental state was noted in 3.4%, cerebral infarction occurred in 0.8% and seizures occurred in 0.3%. The mortality rate in patients with neurologic complications was 29%. (Coffey, C. E. *et al: Neurology* 33:1416-21, 1983)

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago IL 60603.

BLOOMINGTON:
Internal Medicine—to join an active six member group of general internists in Bloomington—Normal, Illinois. Subspecialty in rheumatology or pulmonary medicine desirable, but not necessary. Contact: Judy Buchanan, administrative director, The Health Center, 702 N.E. Street, Bloomington, Ill. 61701. (309) 827-5051. (8)

GIBSON CITY:
Internist/Cardiologist—Excellent opportunity in East Central Illinois; modern, well equipped hospital, sophisticated ICU, attached private SNF: new professional office space and incentives available; rural community within 30 minutes of major university, tertiary care center, metropolitan area with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City 60936. 217-784-4251. (8)

GLEN ELLYN:
Internist to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. Contact: Dave Bauer, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave. Glen Ellyn 60137, 312-469-9200. (5)

GLEN ELLYN:
Expanding multi-specialty group in far western suburbs of Chicago seeks 2 internists. One position involves general internal medicine practice; the other will be essentially a five day per week institutionally based practice with little night or weekend responsibility. Area has excellent schools, housing and recreational facilities. Write: Dave Bauer, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Avenue, Glen Ellyn, Ill. 60137 (312) 469-9200. (8)

KEWANEE:
Population 16,000. Opportunities in Urology, Orthopedics, and Family Practice (solo or associate). One-hundred fifty miles from Chicago, between Peoria and the Quad Cities. Assistance in establishing practice available. Contact: William H. Thieben or Glenn A. Doyle at Kewanee Public Hospital, 719 Elliott Street, Kewanee, Illinois 61443. (8)

MOUNT CARROLL:
G.P./Family Practice, solo practice. M.D. back up available, plus eleven EMTs on local ambulance crew. Small, historic, county seat community in unglaciated portion of northwest Illinois, ten miles east of Mississippi River. Great outdoor recreation, strong sense of community. Financial assistance available. Office space remodeled to suit. Excellent hospital facilities nearby. Contact: Laurie Scott, 302 N. Main., Mount Carroll, 61053. 815-244-1379;244-1407 (H). (5)

PITTSFIELD:
Population 4,200; County: 19,500. 67 bed JCAH accredited hospital completing $2 million addition/renovation in May 1984. Ten active staff members at present. Openings in Family Practice and General Surgery. 75 miles west of Springfield between Illinois and Mississippi Rivers. Recreational facilities abound. Contact: Fred Thompson, 640 W. Washington Street, Pittsfield, 62363, 217-285-2113. (5)

RED BUD
Orthopedic surgeon needed to serve our community. Thirteen active members on the medical staff including family practitioners, general surgeons, internists, and obstetricians/gynecologists. A 105 bed acute care institution and a free standing ambulatory care center located 14 miles from hospital; also owned by hospital. Located 40 miles from downtown St. Louis. This opening presents an excellent practice opportunity to have a busy practice in a rural community. The educational and social amenities of the St. Louis metropolitan area are within 30 minutes yet you may live in the peace and serenity of a rural community with one of the highest rated school systems in the state. A full service and fully equipped institution available in town. Contact H. Herman, Executive Vice President, St. Clement Hospital, Red Bud 62278. (618) 282-3831. (9)

STREATOR:
Community of 22,000, serving population area of 70,000. Located 60 miles from Joliet and Peoria. Fully equipped hospital of 248 beds, with 41 physicians on staff. Cardiology, psychiatry and family practice specialities needed. Practice guarantees provided. Interested physicians are asked to send current resumes to: Terence Schuessler, Adm., St. Mary's Hospital, 111 Spring Street, Streator 61364. (5)

Board Abstracts

(Continued from page 377)

PEER REVIEW ORGANIZATION (PRO)

On August 15, 1983, HHS published proposed rules for the PRO program, the successor to the existing PSRO program. At that time, ISMS decided not to seek designation as the PRO. The Society asked HHS to designate two PRO areas in Illinois (Cook County and Downstate) and also submitted comments on the proposed rules. The chairman reported that Illinois has been designated a statewide PRO. Responses to the HHS Request for Proposal (RFP) are due by April 27th. The Board voted to endorse the Illinois PRO application.

PHYSICIANS' LICENSE FEES

Physicians' license fees flow into a designated fund to support the activities of the Medical Disciplinary Board. ISMS has encouraged greater professionalism by the Board and its employees. The Department has countered that there are insufficient funds to support the activities of the Medical Disciplinary Board. To resolve this issue it has been agreed that physician license fees will be set at $35.00 per year on a three-year cycle (rather than the current two-year cycle) for a total license renewal fee of $105. Additionally, physicians who currently have a Controlled Substances Registration number pay $5.00 per year for renewal of this registration. This fee will be incorporated at $5.00 per year on a three year cycle ($15.00) and included with the license renewal. Thus, a physician will renew both of these at the same time every three years.

FINANCES

Acting on a report of the Executive Committee, the Board transferred $50,000 to the permanent reserve fund subject to the 1983 audited financial report. The preliminary financial statements, as of December 31, 1983, indicate an addition to the Society's surplus of $306,337; an increase of $72,792 over the budgeted addition. Strong fiscal management and increased revenue from the *Journal,* investment income and expense reimbursement added to the 1983 result.

DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: ZORPRIN (Aspirin); DHT (Dihydrotachysterol); PROCAN-SR (Procainamide HCl); INDERAL (Propranolol) 90mg tablet—new strength; TAGAMET (Cimetidine) 400mg tablet—new strength; UNIPHYL (Theophylline, Anhydrous); DECUBITEX Powder and Rh_0 (D) Immune Globulin.

The Board also recommended that the following drugs not be included in the Drug Manual: BLOCADREN (Timolol Malerte); NICORETTE (Nicotine Resin Complex); HYLOREL (Guanadrel Sulfate); SYNALGOS-DC (Aspirin; caffeine; dihydrocodeine); RMS (Rectal morphine sulfate suppository); NATURACIL (Psyllium); FOTOTAR (Coal tar) and SOLAQUIN-FORTE (Hydroquinone).

OTHER ACTIONS

In addressing various other issues, the Board:

- Increased the annual honoraria for the ISMS Chairman of the Board and the President to $35,000 and the annual honorarium for the ISMS President-elect to $15,000, effective with the 1984-85 administrative year. Also agreed to additional compensation for the Chairman of the Board and the President via a company provided automobile. Both actions will be reported to the House of Delegates at the next annual meeting.
- Increased the per diem for members of the Board attending Board and Board Committee meetings to $100 per day, and rescinded the $15 per diem for all other Society Board activities, effective for the 1984-85 Board. This action will be reported to the House of Delegates at the next annual meeting.
- Included officers of the Public Health Service Corps in the membership category of "Service Members."
- Directed that ISMS staff, in response to a request that ISMS review the issuance to the public of a booklet containing physician Medicare profiles by the Comprehensive Health Planning of Northwest Illinois (the regional HSA), assist the local county medical society involved in protesting to the Department of Health and Human Services (DHHS) and the State Health Planning and Development Agency (SHPDA) about the inappropriateness of an HSA expending Federal monies for the publishing of physician Medicare profiles.
- Accepted the Financial Statements for the period ended December 31, 1983; the March 15, 1984,

IMPAC Collection Data Report; March 15, 1984, Membership Dues Payment Report; and Requests for Changes in Membership Status.

- Also accepted the December 31, 1983, audited financial statements and schedules—prepared by Ernst & Whinney—of ISMS, Illinois State Medical Benevolent Fund, Inc., ISMS Educational and Scientific Foundation and the Illinois Council on Continuing Medical Education.
- Authorized the Council on Education and Manpower to participate in a dialogue with the National Advisory Council on Premedical Education to explore areas of concern regarding liberal arts undergraduate studies and medical education.
- Approved proposed guidelines for the ISMS program for Personal Education Plans for Physicians (PEP) to be used during the pilot test of the PEP program.
- Endorsed the concept of creating a medical consultant component which will interact with local newborn care committees under contract to the Department of Children and Family Services to provide medical guidance to state agency personnel and physicians in dealing with child abuse and handicapped infant situations.
- Approved the document, "Guidelines for Medical Care at Large Events," and agreed to publicize its availability to appropriate state, municipal and business groups, as well as the medical community.
- Referred back to the Council on Medical Services for further study, the recommendation that any questions about health fairs sponsored by the National Health Screening Council for Volunteer Organization (NHSCVO) should be responded to by indicating the Society has no objections to the screening protocols used by NHSCVO.
- Agreed that the Illinois Delegation to the AMA will support the adoption of Board of Trustees Report C (I-83) "Poison Control Centers," when it is presented to the June 1984, AMA House of Delegates meeting.
- Agreed to send a letter to all blood centers and hospitals encouraging them to delete references in their donor solicitations, or those of local donor groups, to any terms which imply a blood donation is required to ensure that blood will be available to a person when needed.
- Authorized the receipt of grant funds from the Dangerous Drugs Commission to support CME programs on the disadvantages of substance abuse.
- Following a report on a study by Dr. Sara Charles on instituting a support group/referral panel on malpractice litigation, authorized forming a subcommittee under the Committee on Loss Prevention Education to further pursue this.
- Agreed to advise the Governmental Affairs Council of the Task Force on Health Profession's opposition to revisions to the Nurse Practice Act being proposed by the Illinois Nurses Association, which would permit expansion to independent practice.
- Agreed to: (1) Actively oppose any state legislation that would authorize pharmacists independently to dispense pharmaceutical or therapeutic substitutes to a physician's prescription; and (2) Inform the AMA of ISMS support on this issue.
- Directed that the requirement contained in Section 9, Chapter X of the ISMS Bylaws, which requires component medical societies to forward to ISMS an annual roster of members, be eliminated.
- Discharged the Task Force on Membership Marketing and directed that its functions be transferred to the charge of the ISMS Council on Public Relations and Membership Services. The Board also agreed that county staff representation be retained via their appointment as consultants to the Council on Public Relations and Membership Services.
- Agreed to introduce a resolution supporting a fee freeze.
- Directed that the contributions of Dr. John M. Beal, professor and chairman emeritus, Northwestern University Medical Center, who wrote surgical grand rounds articles for the *Illinois Medical Journal,* who has retired, be acknowledged in the *IMJ* President's Page.
- Directed that a resolution be prepared for the AMA delegation asking the AMA Board of Trustees to report the benefits of unified membership for the states currently unified and the states that are considering it.
- Directed that the Society survey the membership on the issue of unified membership.
- Declared the trustee position from the Seventh District vacant due to incumbent being elected to other office at the Annual Meeting. A replacement will be named at the June Board of Trustees meeting.
- Elected Dr. Alfred J. Clementi, Arlington Heights, as chairman.

APPOINTMENTS AND NOMINATIONS

Various appointments and nominations were approved or ratified by the Board. These were as follows:

- Nominated Dr. Cyril C. Wiggishoff for a position on the AMPAC Board.
- Nominated Joseph Winterhalter, M.D., Jacksonville, for reappointment to the IDPH Emergency Medical Services Advisory Council.
- Nominated Robert Kaufman, M.D., Springfield, for appointment to the IDPH Nutrition Services Advisory Committee.
- Approved the selection of Phillip C. Williams, M.D., Chicago, for the Edwin S. Hamilton Interstate Teaching Award.
- Ratified the nomination of James A. Bull, M.D., East Moline, to the Long Term Care Technical Advisory

Council for the Western Illinois Area Agency on Aging.

- Nominated Pedro A. Poma, M.D., Melrose Park, to serve on the AMA Ad Hoc Committee on Foreign Medical Graduates.
- Appointed Dr. Cyril C. Wiggishoff as Finance Committee chairman and Dr. George H. Burke, as Policy Committee chairman.
- Nominated Drs. Phillip Boren, Alfred Clementi, Robert Hamilton, Jerry Ingalls, Clifton Reeder and Warren Tuttle, to the ISMIS Board of Directors.
- Appointed Dr. Alfred J. Clementi as proxy for the shareholder, Illinois State Medical Society, at the annual meeting of ISMIS, May 2, 1984, to cast the proxy vote for Directors of ISMIS.
- Agreed to submit the names of the following physicians to the IDPA as candidates willing to serve on the IDPA Peer Review and Exception Review Committees (these are in addition to those submitted previously):
 Edward Scollin, M.D.
 Robert L. Vautrain, M.D.
 Donald Rabjohns, M.D.
 Michael Pick, M.D.
 Chausoo Kim, M.D.
 George Burns, M.D.
 G. William Arends, M.D.
 Les Hurshman, M.D.
 Harry W. Bergmann, M.D.
 David Riesenberger, M.D.
 William W. Curtis, M.D.
 Robert L. Prentice, M.D.
 Keith Henry, M.D.
 Rudsen M. Bueser, M.D.
 Audley F. Connor, Jr., M.D.
 William D. Fish, M.D.
 Morris T. Friedell, M.D.
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 Arvind K. Goyal, M.D.
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 Thomas R. Harwood, M.D.
 Joseph Hinkamp, M.D.
 A. Everett Joslyn, Jr., M.D.
 M. Barry Kirschenbaum, M.D.
 Alice S. Mills, M.D.
 Raymond W. Nemecek, M.D.
 Adriano S. Olivar, M.D.
 Camille E. Perkins, M.D.
 Silas Wallk, M.D.
 Ruth Wharton, M.D.
 James H. Andersen, M.D.
 Randall T. Bellows, M.D.
 Lawrence Breslow, M.D.
 C. L. Flanagan, M.D.
 David T. Petty, M.D.
 Samuel M. Schall, M.D.

PROGRAMS

The Board:

- Approved the final development and promotion of a program aimed at reducing the risk of impairment among medical students, predicated on the availability of outside funds.
- Agreed to co-sponsor a program on Physician Impairment for hospital and medical staff leaders.
- Agreed to support a conference on ventilator-dependent children and adults. There will be no cost to ISMS.

INFORMATIONAL ITEMS

- A slide presentation was made relating the progress of ISMS' new headquarters.
- Agreed to inform the Illinois Foundation for Medical Care that there is no objection to their filing bankruptcy should they choose to do so.
- Presented officers and trustees completing terms of office plaques in appreciation of their service.
- Presented certificates of appreciation to ISMS staff members Perry Smithers, 20 years of service; Sylvia Fischer, 15 years of service and Dorothy Freeston, Don Udstuen and Ed Stecki for 10 years of service.
- The Executive Administrator reported on the Wilk Case, Professional Liability Initiatives, Medical Disciplinary Board, a meeting with the Deputy Governor, the March 21 Specialty Society Forum and mandatory assignment.

MEETINGS

The Board set the next Board of Trustees meeting for June 9-10, 1984, at the Arlington Park Hilton, Arlington Heights.

EKG

(Continued from page 416)

Answers: 1. B. C. D. 2. B. C. D.

The twelve lead ECG shows a sinus tachycardia at a rate of 107 beats per minute and frequent premature ventricular beats. The premature ventricular beats occur once in bigeminy ($V_1V_2V_3$) and show an elevated ST segment. A QS pattern is present in leads V_1 and V_2 with ST elevation or injury current in leads V_1 to V_5. This is an acute anteroseptal myocardial infarction whose ECG signs are manifest even in the premature ventricular beats. The QRS vector is isoelectric in lead AVR suggesting a mean QRS axis in the frontal plane of $-60°$ compatible with left anterior hemiblock. There is no voltage evidence for left ventricular hypertrophy. Serum cardiac enzymes were all elevated: SGOT 266, LDH 681 and CK 4120 with mostly MM and trace MB found. These enzymes not only reflected the acute myocardial infarction but also the muscular trauma of cardiopulmonary resuscitation with cardioversion. No pacemaker is indicated for the presence of left anterior hemiblock with acute infarction. Congestive heart failure is manifested by pulmonary basilar rales and a ventricular gallop. There were no clinical signs of cardiogenic shock. The presence of cardiogenic shock is the most severe complication of acute myocardial infarction and is often associated with 40 to 50% left ventricular necrosis. This patient responded to digoxin and other measures. The respirator could be withdrawn. Later a coronary arteriogram demonstrated 100% occlusions of the left anterior descending and right coronary arteries. There was also severe left ventricular dysfunction with an ejection fraction of 12%. Careful consideration of anti-arrhythmic therapy is naturally important. A recent report from the Aspirin Myocardial Infarction Study (AMIS) showed a history of congestive heart failure, cardiomegaly, angina pectoris, multiple myocardial infarctions, and treatment with digitalis and nitroglycerin were more common in patients who died compared to survivors. In addition, cardiac arrhythmia was the mechanism of death in 83% of their patients with coronary heart disease dying in the first twenty-four hours.[1] ◀

References

1. S. Goldstein, *et al: Journal American College of Cardiology* 3:1111, 1984.

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JULY

Family Medicine

Symposium on Computers
For: MDs, RNs, LPNs. Symposium, July 2, 6:30pm, Sangamo Club. **Sponsor:** Springfield Clinic, 1025 S. Seventh St., Springfield 62708-3746. **Fee:** None. **Reg. Limit:** 60. **Credit:** Category 1, 1.5 hours. **Contact:** Ernesto B. Eusebio, M.D. **Phone:** 217-525-4524

Clinical Medicine Update
For: GPs, FPs. Lecture, July 23-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $390. **Reg. Limit:** 90. **Credit:** Category 1, 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Risk Factor Management

Risk Factor Management
For: MDs, RNs, Allied Health Professionals. Workshop, July 9-13, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

Cardiac Rehabilitation

Cardiac Rehabilitation Workshop
For: MDs, RNs, Allied Health Professionals. **Workshop:** July 9-13, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's. **Contact:** Philip K. Wilson, Ed.D.

OB/GYN

Gynecologic and Obstetric Surgery
For: Obstetricians and Gynecologists. Course, July 12-14, Rosemont. **Sponsor:** American College of Obstetricians and Gynecologists, 600 Maryland Ave., S.W., Washington, DC 20024. **Fee:** $315 ACOG Fellows & Jr. Fellows; $158 Jr. Fellow Residents, Life Fellows; $365 Others. **Reg. Limit:** TBA. **Credit:** Category 1, 16 hours; 16 Cognates of ACOG. **Contact:** Patience A. Schenck. **Phone:** 202-638-5577

Weight Control

Weight Control Workshop
For: MDs, RNs, Allied Health Professionals. Workshop, July 16-20, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's.

Emergency Medicine

Fourth Annual Common Emergency Care Problems
For: MDs, RNs, Allied Health Professionals. Conference, Workshops, July 19-20, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1 TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Specialty Review in Emergency Medicine
For: MDs. Lecture, July 30-August 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $480. **Reg. Limit:** TBA. **Credit:** Category 1, 45 hours. **Contact:** Robert J. Baker, M.D **Phone:** 312-633-2600

Pediatrics

Specialty Review in Pediatrics
For: Pediatricians. Lecture, July 23-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** TBA. **Credit:** Category 1, 65 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, July 31, 6:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green By Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

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AUGUST

Surgery

Soft Tissue Surgery Workshop
For: MDs. Workshop, August 4-5, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $290. **Reg. Limit:** 60. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Specialty Review in General Surgery, Part II
For: Surgeons. Lecture, August 20-31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Reg. Limit:** TBA. **Credit:** Category 1, 100 hours. **Contact:** Robert J. Baker, M.D **Phone:** 312-633-2600

Fiberoptic Colonoscopy
For: MDs. Lecture, August 22-24, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Fiberoptic Esophagogastric Endoscopy
For: MDs. Lecture, August 27-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Sports Medicine
Seventh Annual Sports Medicine Symposium
For: MDs, Sports Professionals. Symposium, Workshop, August 3-4, Waunakee, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AOA, TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Urology, Radiology
Endourology and Ureteroscopy: Triumphs and Pitfalls
For: Urologists, Radiologists. Lecture, August 3-4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 90. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Radiology
Sixth Annual Cape Cod Summer Symposium on Ultrasound, CT, and MR
For: Radiolgists, Technicians. Symposium, August 6-8, Hyannis, Massachusetts. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $250 MDs; $175 Res., Tech. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; UW-Extension CEU's, 13. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Internal Medicine
Specialty Review in Internal Medicine/Certifying
For: MDs. Lecture, August 5-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** TBA. **Credit:** Category 1, 72 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Clinical Medicine
National Symposium on Sexually Transmitted Disease
For: MDs. Symposium, August 10-12, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** Skokie Valley Hospital/Foundation, Program Office, 9600 Gross Point Rd., Skokie 60076. **Fee:** $295. **Reg. Limit:** 400. **Credit:** Category 1, 15 hours; AAFP Prescribed, 15 hours. **Contact:** Craig Olesen. **Phone:** 312-677-9600, Ext. 3354

Medicine and Pathology
Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, August 28, 4:30-6:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

SEPTEMBER

Medicine
Gastrointestinal Disorders
For: MDs, Office Staff. Symposium, September 6, 2:30pm, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

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For: MDs, RNs, Allied Health Professionals. Workshop, September 10-14, La Crosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's.

Neurology, Pharmacology, Psychiatry
Headaches: Biological Mechanisms and Clinical Aspects
For: MDs. Lecture, September 12, 8am, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, Departments of Pharmacology, Neurology & Psychiatry, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $50 MDs; $25 Others. **Reg. Limit:** None. **Credit:** Category 1, 6 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Surgery
Visiting Professor Lecture Series
For: MDs. Lecture, September 12, 2pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, Department of Surgery, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

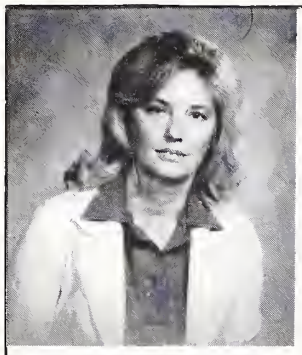
Nuclear Cardiology
Ninth Annual Nuclear Cardiology Symposium
For: Cardiologists, Radiologists. Symposium, September 19-22, Milwaukee, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; UW-Extension CEU's, Voice Credit. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Medical Practice
Second Annual Conference on Current Medical Events
For: MDs. Symposium, September 20-21, Springfield. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Infection Control
Advances in the Control of Nosocomial Infection—1984
For: MDs, RNs, Allied Health Professionals. Conference, September 20-21, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Use of New Antibiotics
For: MDs, Office Staff. Symposium, September 22, 1pm, Mt. Carmel, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Medicine and Pathology
Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, September 24, 6:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, Departments of Medicine & Pathology, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215



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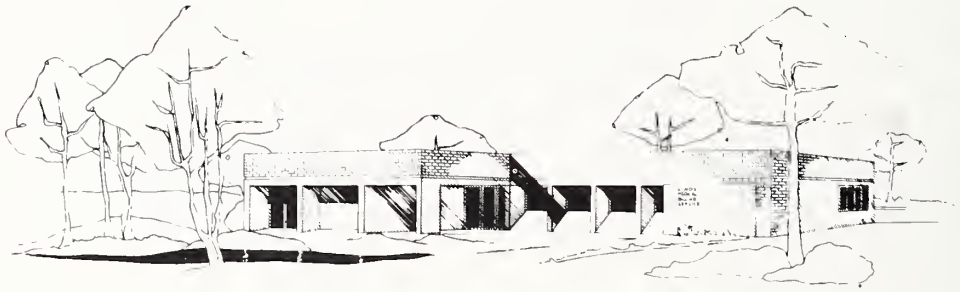
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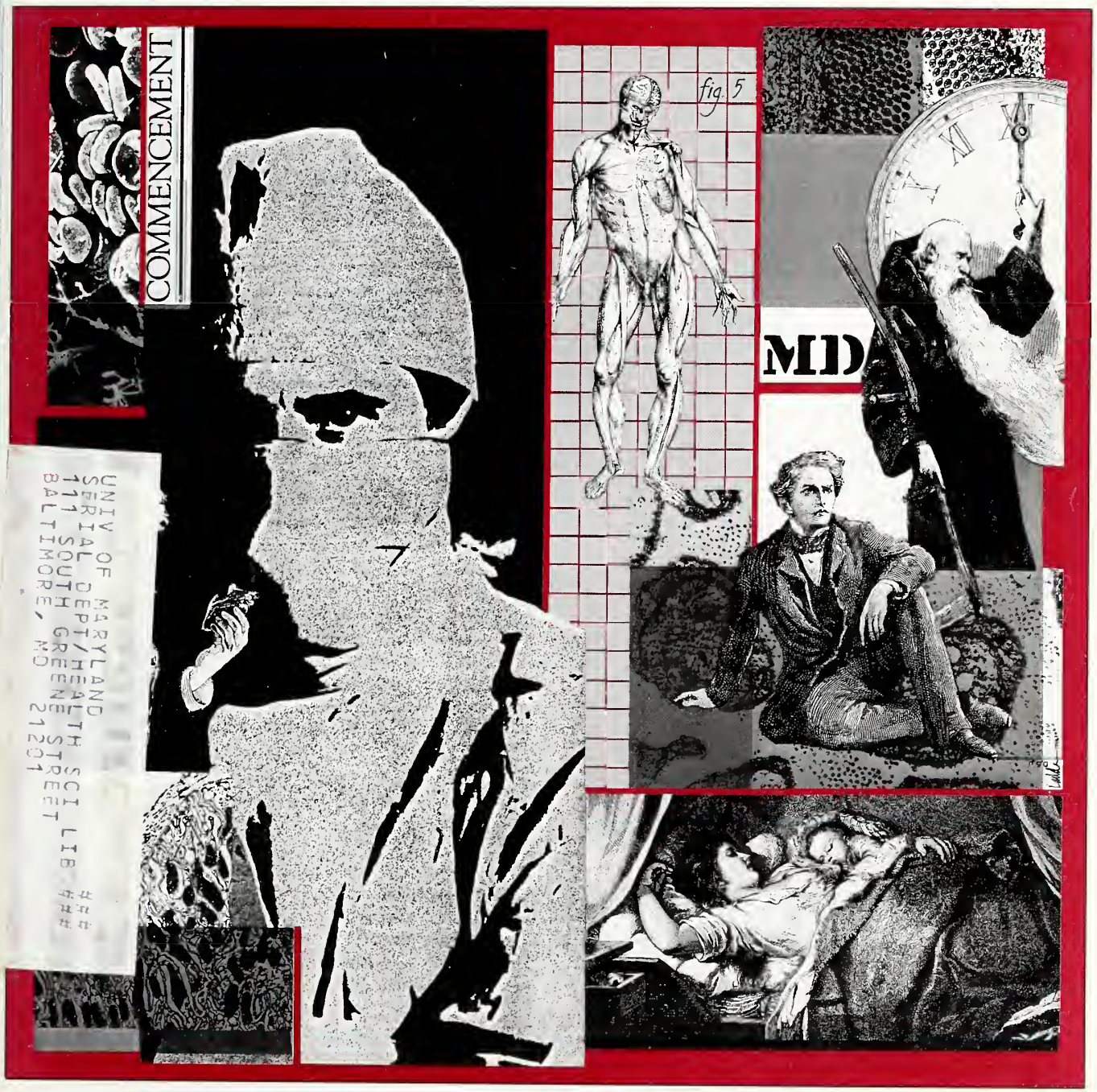
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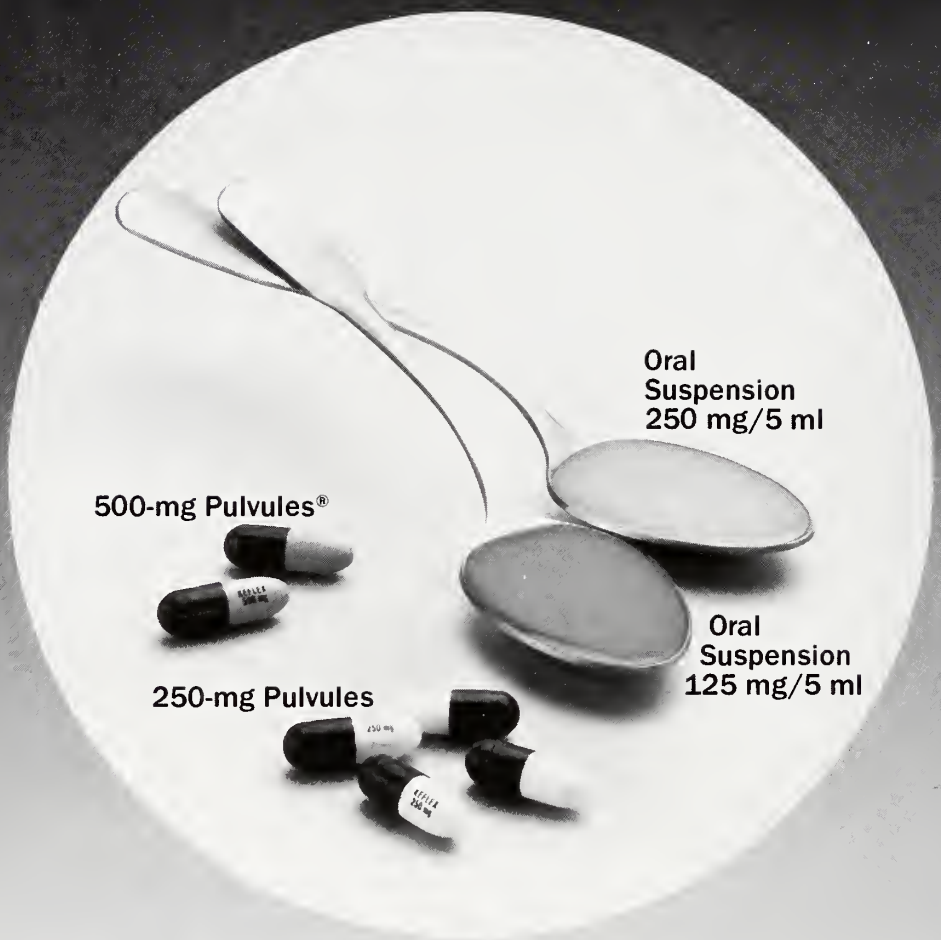
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Illinois State Medical Society

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Epitaph for a Physician



Last month, a friend of mine died.

Claude Needham Lambert, M.D., was an orthopaedic surgeon who practiced and taught in Chicago for over forty years, touching and enriching the lives of countless patients and students. I was, and will always remain, one of the latter.

Born in Salt Lake City 01 June, 1903, he was brought up in New Zealand by his missionary parents. Always proud of his Mormon heritage with its emphasis on family, he treated almost everyone he met, professionally and socially, as members of his family, and they reciprocated.

He was a Doctor, in the original Latin sense of the word: one who teaches. After finishing pre-med at Utah, he came to the old Rush Medical College at the University of Chicago. After graduation, he interned at old St. Luke's Hospital, beginning a life-long association with it and its successor, Rush-Presbyterian-St. Luke's Medical Center, from which he retired as professor emeritus. Following residency at the University of Illinois Research and Educational Hospitals, he joined the orthopaedic faculty there and retired also as professor emeritus. The dual professorship is almost unique in academic circles; it demonstrates both the regard of his colleagues and his loyalty to the institutions.

He was a Physician, in the true sense of that word: a healer of the sick and afflicted. Although he treated young and old alike with the interest and compassion of a family member, his great love was treating crippled children and they loved him in return. He initiated clinics for scoliosis and juvenile amputees and lived to see similar clinics formed throughout Illinois and beyond, conducted by those he trained. He had a special regard for the amputees and they knew it. He attended graduations and weddings of these patients—his family—and always kept abreast of their personal lives as well as their clinical progress. Dr. Lambert was also instrumental in organizing the Northwestern University Prosthetics and Orthotics Center, where he held a third academic appointment: lecturer in orthopaedic surgery.

He was a Surgeon, in the original Greek sense of the word, being a "worker with his hands." His skill and dexterity in the operating room and the gentleness and respect which he gave to tissues were exceeded only by the way he treated the whole patient. When physical weakness prevented him from performing surgery, he supervised. When this was impossible, he turned his hands to needlepoint; ever the surgeon, he applied his skills even in retirement.

He was an officer and/or founder of the societies to which all young orthopaedic surgeons now aspire and was proud of his membership in the ISMS 50 Year Club. He displayed the same leadership while serving to lieutenant colonel in the Army Air Corps during World War II.

His death signals the end of an era. The years from the thirties to the eighties represent a truly golden age in medicine and surgery: pre-antibiotic to CAT scan. He practiced his art and science freely within the limits of his own stringent conscience. Charity came frequently from his heart, not public funds. He continued his education constantly for its own sake and the benefit of his patients; he was devastated when his Illinois license had to lapse because he was physically unable to obtain required CME hours. He was never touched by malpractice until the cost of insurance prohibited him from making official consultations, although his advice was sought and freely given to his colleagues. *O tempora, O mores.*

Although the environment of the practice of medicine has changed, the true profession of medicine must not. We must remember, as he did, that the ultimate satisfaction is that of seeing the crooked child straight, the lame child walk, and the sick healed.

He died peacefully, at home, 18 June 1984. I have lost my father confessor and friend, but his spirit will live on and serve as an inspiration to all who follow. ◀



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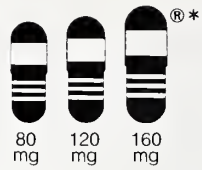


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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
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Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

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INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

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PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

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Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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Ayerst AYERST LABORATORIES
New York, N.Y. 10017

THE VIEWBOX

Contributing Editor Terrence C. Demos, M.D., Professor of Radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was prepared by Donald J. Kash, M.D., department of radiology, Loyola University Medical Center, Maywood.

A healthy 56 year old man had a chest radiograph (Figure 1) as part of an employee physical examination. He had no past medical problems but had smoked heavily for more than 40 years.

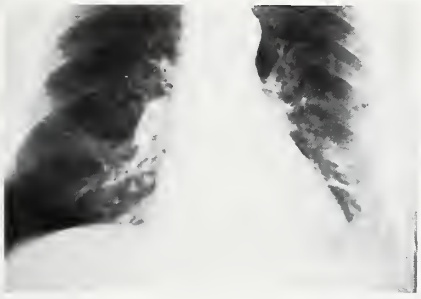


Figure 1A
PA chest radiograph. There is a rounded mass near the apex of the heart plus pleural changes at the left costophrenic angle.



Figure 1B
Closeup of the left lower lobe mass. Note the curvilinear density (arrows) extending toward the hilum. The pleural density did not change in a decubitus view and represents pleural thickening.

Your Diagnosis?

1. Bronchogenic Carcinoma
2. Round Atelectasis
3. Mesothelioma
4. Loculated Empyema
5. Fungus Ball

(Continued on page 49)

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First-step blood pressure control with optimal simplicity

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Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

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Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

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CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

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The Person at the Bottom of the Pile

Dear Editor:

The 10:00 a.m. coffee roundtable has been together for a long time. One member may drift off and another may become a regular attender, but by and large it's the same group. Like many groups that stay together, it is made up of individuals with differing views coming from different backgrounds and with different talents but with a primary single objective to which all can bend those talents and prejudices. That objective is good conversation, lively discussion, mediocre coffee and fry cakes that lay in one's stomach for the rest of the morning.

As the reader in the group, I brought to the table the information that a Rand Study said that of the multibillion dollars that will go from the asbestos industry to individuals allegedly injured by asbestos, 60 percent would go to the lawyers. Chester, our real estate and insurance member, opined that after all that's what insurance was for—to pay for losses incurred through accidents, acts of God, etc. Lonny, our retired principal who at one time taught math, picked up that challenge, stating that premiums are what paid for it even though the money seemed to come from the insurance company. Whereupon going around the table and working his pencil on the tablecloth, he noted that of the six members present representing ten cars, a pickup truck, and an old jeep, we were paying approximately $12,000 a year in premiums for auto insurance; probably another $10,000 in health insurance, and $5,000 or $6,000 in property, home and other kinds of insurance. He quickly got that total for just us around that table up to $35,000 a year.

Lefty interrupted the deafening silence that followed that announcement with a crack about "no wonder you never have money left over to leave a tip."

It became painfully apparent as the conversation came and went that all of that money that all of us were putting aside was where the big insurance company got theirs. "Seems clear," said Lonny, "it isn't the big insurance companies that pay off these claims—it's the folk that pay the premiums!"

Chester with surprising candor responded with, "I pay the premiums to my insurance company for my liability insurance, but I don't really pay those premiums. I really charge my customers a little bit more so that I can pay those premiums."

Asa rocked back on the back legs of his chair, keeping one foot hooked in the rungs and the other under the lip of the table to keep from falling backwards and said, "Folks and lawyers that view the insurance company as a pot of gold to be dipped into have to realize that the only thing you get for nothin' is nothin'. If you get somethin', it comes from somethin' and someone. And it's the person at the bottom of the pile that usually coughs up the dough."

Certainly Asa is right again—"the only thing you get for nothin' is nothin'." ◀

Emerson Goodwins

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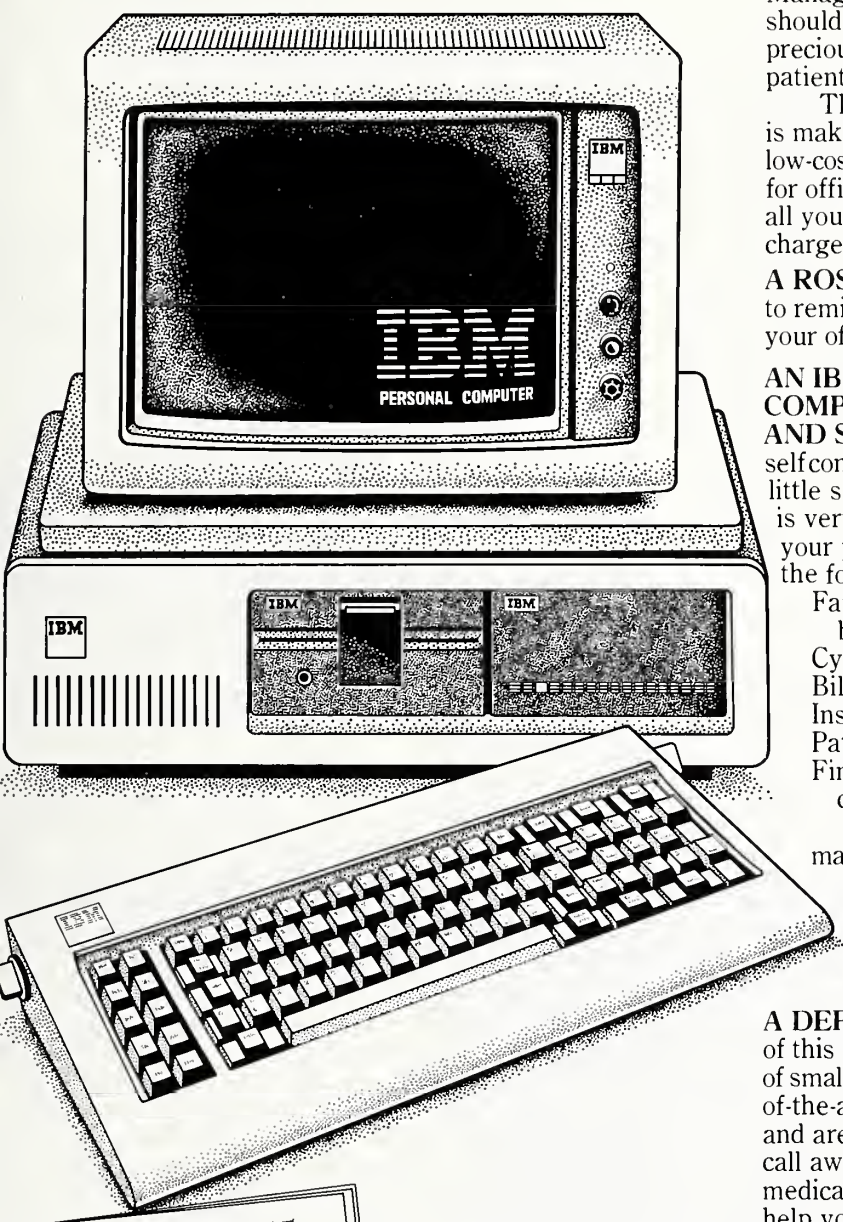
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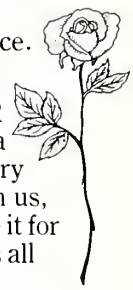
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DOCTOR'S NEWS

MALPRACTICE MAELSTROM

A number of our members have called to inquire about correspondence on the ISMS malpractice initiative. The correct sequence of events is as follows.

In May, the Illinois Trial Lawyers Association (ITLA) mailed a letter to all Illinois physicians regarding the malpractice crisis. This prompted a clarification letter from ISMS to all members. The ISMS response was sent via first class mail on May 21.

It seems that because the initial ITLA correspondence was sent by bulk mail, some members received the ISMS response weeks before the ITLA letter. In fact, the ITLA letter is still arriving in some parts of the state. Members with further questions are encouraged to contact the ISMS offices.

LICENSE RENEWAL CLARIFICATION

The 1984 medical license renewal forms from the Department of Registration and Education state that only certified checks will be accepted for license renewal fees. ISMS has been assured by staff of the office of the director, Department of Registration and Education, that personal checks will also be accepted.

Illinois medical licenses are subject to renewal as of July 31. Beginning this year, the Department implements a new three year renewal cycle, a regulatory change pursuant to new legislation. Extension of the renewal cycle from two to three years was intended to save administrative costs. Physicians who have not yet received official notice of license expiration should contact the Department immediately at 320 W. Washington, Springfield 62786 (217-785-0800). ◂

FOCUS ON IMPAIRMENT

Two CME programs will be sponsored this summer on physician impairment.

The University of Illinois College of Medicine will sponsor the second annual conference on "Stress, Impairment and the Resident," at their Chicago campus on August 2-3. The program, which was endorsed by the ISMS Resident Physician Section, is designed for residency program directors, department heads and medical staff. Those who attend will earn 14 hours' Category 1 CME credit. Registration fee is $170. Further information may be obtained by writing Jeff Beaudry, coordinator, UI Chicago, Conferences and Institutes, 912 S. Wood St., Chicago 60612.

The sixth annual AMA Conference on the Impaired Physician will be held September 6-9 at the Meadowlands Hilton, Seacaucus, New Jersey. The conference is intended to provide information on implementation of impaired physician programs and provide a forum for professionals who work with impaired physicians. Further information is available from the AMA, 535 N. Dearborn, Chicago 60610.

PHYSICIANS IN THE NEWS

George G. Jackson, M.D., Chicago, has been awarded the 1984 Ernst Jung Prize for Medicine, a West German international honor dedicated to "pioneers in medicine." Dr. Jackson, head of the section of infectious diseases, University of Illinois, Chicago, was recognized for his teaching and research in that field.

Students at the University of Illinois College of Medicine voted to honor ten Illinois physicians with the "Golden Apple" awards for teaching excellence. The Chicago campus students voted to present the award to **Philip B. Gorelick, M.D.,** Lincolnwood and **Olga Jonasson, M.D.,** Chicago. At the UI College of Medicine, Peoria, **Drs. Ralph L. Gibson** and **Richard P. O'Connor, Jr.,** were chosen. **Drs. Richard F. Novak, Glenn D. Netto, Richard S. Webb** and **Kent J. Hess** were the UI Rockford faculty selected. At the Urbana-Champaign campus, Golden Apples were presented to **James A. Cowan, M.D.,** and **Garron M. Lukas, M.D.,** both of Urbana.

George H. Pollock, M.D., president, Chicago Institute for Psychoanalysis, was recently re-elected treasurer of the American Psychiatric Association.

Herta Spencer, M.D., Oak Park, a professor of medicine at the Loyola University of Stritch School of Medicine and chief of the metabolic section, Hines VA Hospital, recently was chosen to receive the 1984 Borden Award in Nutrition from the American Institute of Nutrition.

Robert T. Swastek, M.D., Chicago, was named president of the Illinois Academy of Family Physicians (IAFP) at its annual meeting last month. At that same meeting, **Delbert Harris, M.D.,** Lebanon, was named speaker of the congress of delegates. Also, **Dr. Mack Hollowell,** Charleston, was elected to a two year term as alternate delegate from Illinois to the American Academy of Family Physicians. (Dr. Hollowell is the immediate past president of the IAFP.)

EMERGENCY MEDICAL TRANSPORT

Lifeline is a non-profit organization of private pilots who donate their time and equipment to fly medical supplies, blood, organs and health personnel to isolated areas to assist in emergencies and disaster relief operations. It serves medical facilities, social service agencies and service organizations. The association is coordinated through the Illinois Emergency Services and Disaster Agency (ESDA) in Springfield. Requests for pilot services should be directed to the ESDA (217-356-0260).

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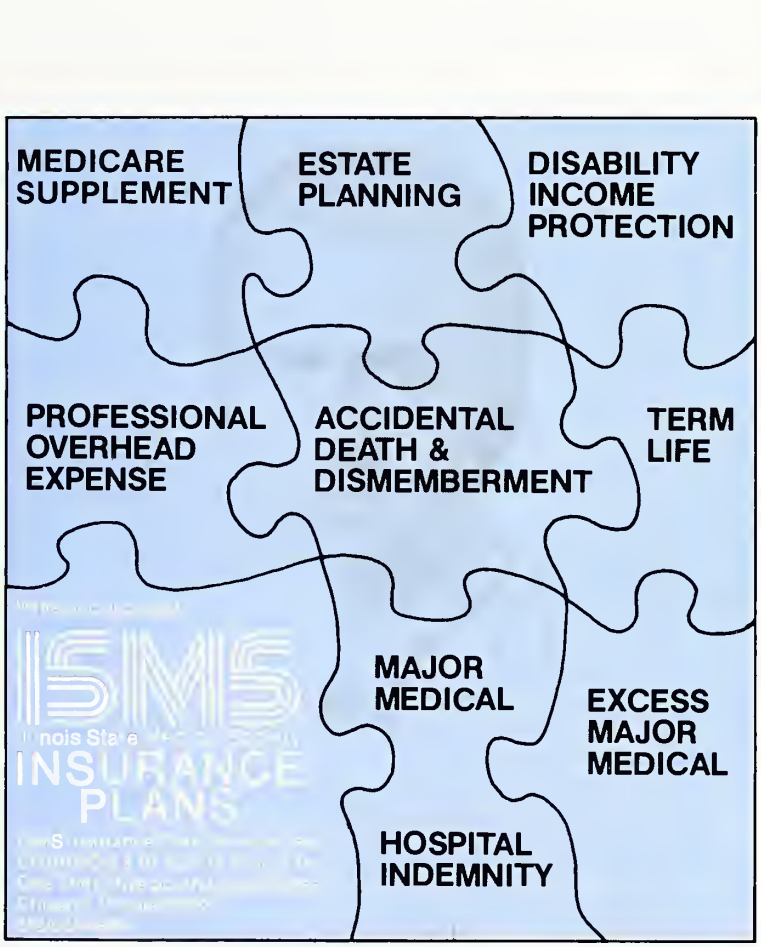
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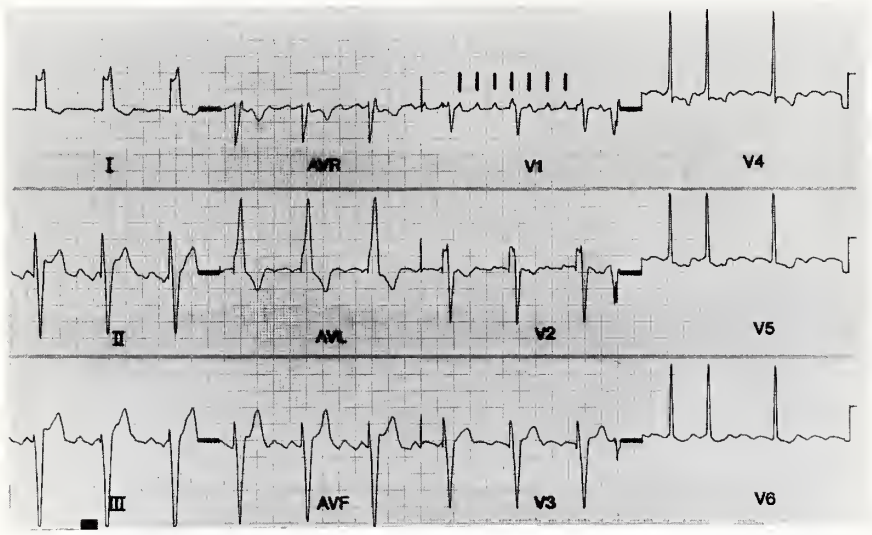
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a seventy-eight year old lady who came to the emergency room with a complaint of sudden onset dyspnea. She had a history of diabetes mellitus and peripheral arterial insufficiency. One year ago she had had an extensive anterolateral myocardial infarction with a complicated prolonged course. On the fifth day, she had more pain and apparently extended her infarction. Complete left bundle branch block developed and was followed by intermittent 2:1 atrioventricular (AV) block. The next day, ventricular tachycardia was followed by ventricular fibrillation. She was successfully defibrillated and resuscitated. Now she enters the hospital emergency service with a three hour history of worsening dyspnea. She denies any chest pain. Her blood pressure is 144/88mmHg and pulse is 70 beats per minute. Her lungs have bibasilar rales and a ventricular gallop is present on examination of the heart. The twelve lead ECG is obtained.



Questions:

1. The twelve lead ECG shows:
 a. Accelerated idioventricular rhythm.
 b. An acute myocardial infarction.
 c. A well functioning ventricular demand pacemaker.
 d. Atrial flutter.
 e. Intermittent complete left bundle branch block.

2. Appropriate measures to manage this patient would include:
 a. Diuretic therapy.
 b. Digoxin.
 c. Pacemaker revision.
 d. Procainamide in doses to maintain adequate blood levels.
 e. All of the above.

(Continued on page 51)

EXCLUSIVE

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The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

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The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

*In Illinois, TALWIN Nx is a Schedule II controlled substance and requires a triplicate prescription.

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Please see following page for Brief Summary.

Talwin® Nx® (IV)

Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, 0.5 mg

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TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions. Usage with Alcohol:* See **Warnings.** *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C:* Should be given to pregnant women only if clearly needed. *Labor and Delivery* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman. *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular* Hypotension, tachycardia, syncope. *Respiratory* Rarely, respiratory depression. *CNS: Acute CNS Manifestations:* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours; may recur if drug is reinstituted. *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal:* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic:* Edema of the face; dermatitis, including pruritus, flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic:* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other:* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported, there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

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**Additional NMR Information on page 48*

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 166, No. 1
July 1984

Residency Training and Emotional Problems of Physicians

By Jerome A. Winer, M.D. and Carlton Ferrono/Chicago

Recognition of the psychological vulnerabilities of physicians has increased in the past decade. Much of the research on the subject emphasizes either personality characteristics or the stresses and strains of their professional role. The authors suggest a complementary perspective and approach to this problem—the interaction of the special demands of residency training with five lines of normal adult development. These include adult developmental lines of work, play, mentor relationships, attitudes toward and care of one's body, and concerns about time limitations and death.

An earlier version of this paper was presented at the Midwest Clinical Conference of the Chicago Medical Society on March 13, 1982.

This paper will examine the disruptive influence exerted by postgraduate medical education on certain normal lines of personality development in early adulthood. It will also consider the potential long term adverse effects on the resident as physician and individual. Psychodynamically-oriented thinkers have recently come to view psychological development as not confined to the childhood and adolescent years, but extending throughout the life course.[1] Less closely tied to biological changes than is childhood development, development in adulthood is intimately bound up with the interpersonal and social worlds. By middle age, an individual has most often firmly established a sense of personal and professional identity, as well as marital, familial, and social commitments. The young adult is often only beginning to accomplish these tasks. For the medical resident, who usually undertakes postgraduate education in the mid- to late twenties, these normal developmental paths can be influenced by the nature and quality of his training in a way that leaves a lasting mark on his personal and professional life. Based on the work of Anna Freud,[2] Levenson, *et. al.*,[3] and Colarusso and Nemiroff,[4] the authors have selected five lines of psychological development as particularly pertinent to the training of physicians: 1) Work, 2) Play, 3) Mentor Relationships, 4) the Body, and 5) Time and Death. *We shall use the male pronoun but believe that all situations we discuss affect both male and female residents.*

Work

If the first steps toward developing a career have already been taken by the individual's decision to enter medical school, choosing a residency is perhaps an even more decisive step in solidifying a work identity. At this point, he must accomplish two major tasks. First, he must be able to focus his interests and talents in one area, giving up the fantasy of "omnipotentiality."[5,6] Second, he must make the transition from being a student, a more or less passive learner, to being a physician, an active, independent, "doer," with the sense of primary responsibility for others that this role entails.

The fantasy of omnipotentiality has several components which involve the resident's feelings about himself and his chosen profession. There are few, if any, other occupations which offer as many options for the young individual as does medicine. During medical school,

when he was not doing well in, or did not enjoy a given area, he retained the prospect of doing something else, later. However when he has to choose a residency, he must commit himself to one role, focus his energies and interests, and define a career line. This transition may be relatively easy for some, but for many it is fraught with ambivalence and psychic conflict which is played out in the residency itself. In this regard, Ekstein[5] notes the similarity between the adolescent identity crisis and the post-adolescent work identity crisis found in some beginning psychiatric residents, an observation which can be extended to other medical specialties. He writes: "Behind the feeling that he can do everything, behind the competitive striving—often expressed in authority problems with school administration, competition with other residents, and the struggle with the supervisor—lies a feeling of helplessness."

These feelings of helplessness are phase-specific in a sense. No longer a student, the beginning resident is now a physician, charged with the responsibility of attempting to master a new and complex set of practical activities. In addition, he bears the heavy burden of primary responsibility for the lives and well being of patients, who often view him as magically powerful. Especially in the first years of training, disparity between the powers and responsibilities that the title of "Doctor" confers, and the resident's own experience of his relative lack of skills and expertise, may lead to feelings of anxiety and helplessness. A regression to omnipotentiality as a defense against these feelings may occur. On occasion, this leads to a fixed and permanent grandiosity, which persists later in his career and is manifested in the physician's thinking that he can be all things to all patients, leaving him dangerously unaware of his own limits and shortcomings.

Sharaf and Levinson[7] point to another defense which the resident may employ to counter feelings of helplessness and to bolster self esteem. As a means of coping with the immense challenges they face, residents may come to view not themselves, but their teachers, as omnipotent. This belief is often coupled with the belief in "professionality," that is, that membership in an elite occupational group not only provides one with the "right ways" of dealing with problems, but also with knowledge which is unavailable to outsiders, and the unquestioned understanding, acceptance and support of colleagues. When carried to an extreme, this can serve as the basis for the physician's almost addictive need to be in contact with other physicians. This extreme can foreclose other social intercourse, narrow his perspective, impoverish his life and, at the very least, make him a ruthless bore.

The actual work load of the beginning resident has more immediate psychological effects. Valko and Clayton[8] found that 30% of PGY-2 residents in seven specialties had experienced a diagnosable depression during their internship. Neither stressful life events nor the medical, social, and childhood histories differentiated the depressed and non-depressed groups. However, two other factors appeared to be significant. Almost 70% of the internship depressions began in the first or second month of the training year, emphasizing the difficult nature of the transition from student to primary care physician. Also, 63% of the depressed interns were working on rotations which required over 100 hours of service time, and depressed residents were significantly more likely to have made rounds seven days per week. However, it cannot be determined whether the work load itself is the causative factor in the depression. Perhaps residents who perceive a discrepancy between their skills and knowledge and their (grandiosity-fueled) expectations of themselves as "doctors" may place additional time and service demands on themselves. Or they may use work as an escape from personal or marital problems. The heavy work load may only feed into an already formed pattern of difficulty and defense. Nonetheless, the extent to which the internship year may evoke psychological distress is well documented. Of the depressed group, 31% stated that, given the decision to make over again, they would not choose medicine as a career.

Play

Play, no less than work, is an essential ingredient of normal, healthy adulthood. Both work and play offer opportunities for the expression of one's personality, for pleasure in the activity itself, as well as in the achievement of a finished product, for neutralization and sublimation of libidinal and aggressive impulses, for positive investment of the body and its skills, for increased self-esteem and for companionship and intimacy with others.[2,4,9] Insofar as play—including symbolic activities, sports, games, hobbies and daydreaming—is undertaken for purposes of pleasure and with relative disregard for external pressures and exigencies, it serves a revitalizing purpose, acting as a tension-reducer and cathartic. However, the demands of the residency may upset the healthy balance between work and play, as the resident feels he must devote his energies and interests exclusively to learning his trade. Exhausted from his duties, he may feel there is little time or energy "left over," to devote to play and recreation. Thus, although the popular image of the physician includes many hours on the tennis court or golf course, this is rarely the case. In fact, he all too frequently gets almost no recreation, often because he has dropped his capacity for healthy play during the residency and has never returned to it. This avoidance of age appropriate play contributes to the neglect of his body, his friends, and especially, his family, since play activities can—sometimes literally—be the ballpark for meaningful and pleasureable mutual involvement. Medicine has become his hobby, avocation, passion, and recreation, which serves neither the patients nor the practitioner very well in the long run.

Mentor Relationships

Levinson and associates[3] in their study of male adult development, point out the characteristics and function of the mentor, calling the mentor-mentee relationship one of the most complex and developmentally important of early adulthood. Levinson describes the mentor as usually being older than his mentee by a half-generation, roughly eight

to fifteen years, of the same sex and as a person of greater experience in the sphere that the young man is entering. The functions he serves are many. He acts as a *teacher,* enhancing the young man's technical skills and intellectual development. As *sponsor,* he may use his influence to facilitate the novice's career entry and development. He serves as *host* and *guide* for the initiate in a new occupational, political, and social world, introducing him to its customs and values. He may, through his achievements and personal virtues, be an *exemplar* and *role model* the protege admires and seeks to emulate. He provides *counsel* and moral support. Finally, Levinson *et al.,* note, the mentor provides another service. He fosters the young adult's development by believing in him and in his dream, to which he gives his blessing. As the young man gains a fuller sense of his own authority the relationship becomes more mutual. This crucial developmental shift is part of the process by which the young man transcends the man-boy division of his childhood.

The relationship of the resident to his physician-mentors is perhaps the most important of his career, not only as a doctor, but as an adult. It is from the mentor that he learns, in its widest compass, what being a physician means. However, students entering medical school often know very little about medicine as a profession and lifestyle. Roeske[10] reports that 13.2% of male, and 6.7% of female first year medical students had neither discussed medicine as a career with a physician, nor had worked in a health care setting. The number who have had only passing contact with a guiding professional is, in all probability, much higher.

But it is precisely one of the central tasks of young adulthood to find an individual one can respect, with whom one can work, and from whom one can "learn the ropes." Sharaf and Levinson[7] state that it is because of the residents' acute sense of incompetence and inner void that they seek out mentors who offer what they themselves lack. Once found, the mentor can serve two purposes. He is used as a role model and source of competence, but at an unconscious level, he can be used as a magical figure in a fantasy of future omnipotence.

Difficulties may arise at both the conscious and unconscious levels. First, there is the problem of *finding* an appropriate role model. Traditionally, physicians involved in training programs are more likely to be interested in academic medicine and research, rather than in primary patient care. There is, then, a shortage of models for the vast majority of students who will be involved primarily in direct patient care. The fact that there are relatively few women or minority physicians involved in academic medicine may make it difficult for female or minority residents to find an appropriate mentor with whom to identify. Foreign medical school graduates, as well, may have an especially difficult time in this regard.

Second, at the unconscious level, the resident's view of his medical superiors as magical, omnipotent figures may distort or inhibit the learning process. Instead of forming his own sense of identity, the student may merely imitate the admired figure in his external features. Identification with such a figure may be so massive that the resident cannot judge the merits of anyone holding divergent views from the mentor's. Such an idealizing stance may also foster rather than alleviate the resident's sense of ineffectuality. This is especially likely when the mentor is overly critical or narcissistically unaware of his impact on the student. The resident may feel that he will never become as skilled or knowledgeable as the "great man," and that he will never "measure up" in this figure's eyes. Further, there is also the potential for rapid and catastrophic de-idealization of such a figure when the god is seen to have clay feet, to make mistakes and to have all too human frailties.

Although aspects of the mentor-mentee relationship may have a pathological tinge, in its more normal and healthy form, such idealization of the mentor when gradually moderated is a normal developmental process in young adulthood. The fate of the resident who does not find an appropriate mentor, or fails to seek and develop such a relationship, is especially problematic. This may happen to two types of student. It is seen in the introverted, unexceptional student, suffering from problems of self esteem, in whom no one takes a special interest, and who forever seems to get lost and forgotten in the crowd of his more demanding and/or talented peers. It can also happen to the "arrogant," iconoclastic resident, who will not allow himself to trust, idealize or be apprentice to anyone. Like the rebellious adolescent, he may either sarcastically depreciate or actively militate against all forms of authority, relying instead on his own embattled resources, and his own, sometimes faulty judgment and expertise.

Even for normal, emotionally healthy residents, separating from the mentor may require a mourning process. Here, the mentee identifies with the lost love object, in order to later become a mentor himself. Either the absence of an appropriate mentor relationship or an incompletely mourned relationship can result in hunger for (or, rebellion against) such a figure long after formal training is finished. This results in a career and personality that is best described as a *forme fruste:* in some ways, this physician remains a perpetual resident, failing to develop his own mature authority, and to become a responsible mentor for the next generation.

The Body

Age appropriate attitudes toward one's body, its care and limitations, represent a developmental line of special significance to physicians. While, for most adults, the body is not a source of preoccupation and concern until middle age[11] several factors may precipitate an "off-time" awareness of the body in the young adult resident. First, there are the enormous physical and emotional demands placed on the resident, particularly during his first year, when he may be called upon to work 100-hour weeks and may experience long periods without rest or recreation. Because of his role as physician, the resident is primarily concerned with bodies and their functions and dysfunctions. He is regularly confronted by

the myriad ways in which a person's body can betray him. The frequency with which he encounters bodily illness and injury may lead to a denial of his own bodily vulnerabilities which is not always adaptive. He may feel that the regulation of diet, exercise, and sleep which he may prescribe for others does not apply to him. Preoccupied with others' bodies, he may neglect or abuse his own body, through drinking, self-medication, or a failure to recognize his own physical or emotional limitations. Even when ill, physicians are notoriously bad patients and often receive bad care from other physicians. When being "special" means that comprehensive routines are altered or the normal doctor-patient relationship is abrogated, much may slip through the net.

The physician's relationship to his own body has important effects on his treatment of patients' bodies. For the resident with little or no personal experience of severe pain, fear of manipulation by patients or of adverse criticism by colleagues may lead him to withhold pain medication in appropriate circumstances.[12] Denial of his own bodily needs and distresses may also contribute to failure in perceiving the distresses and concerns patients have about their bodies. The trainers of residents often fail to teach the resident how to deal with the patient's anxiety or depression over lost functions or prolonged illness. While the resident consciously fails to perceive or minimizes his patient's distress, on deeper levels his incapacity to relieve that distress, to make his patient comfortable, may gnaw at him. This, in itself, may contribute to the abuse of his own body, via alcohol, drugs, or even psychosomatic illness.

Time and Death

Concerns about time limitations and death are usually markers of middle age.[11] In dealing with the terminally ill patient and his family, the resident physician encounters these issues much earlier than do most people, albeit at one remove. Defensive denial of the psychic reality of death is a common reaction which becomes a fixed aspect of his character structure. The resident may maintain an emotional distance from the patient, taking a "dispassionate" interest in the disease. He may initiate desperate and futile heroic measures, not able to acknowledge to others or to himself that the patient is dying. He may adopt a casual, even cavalier, attitude toward death, including the prospect of his own death or, pursued by its specter, he may shift into a state of chronic hyperactivity in order to demonstrate to himself continually that he is, indeed, alive. Only recently has thanatology been a subject of medical study and teaching, and few physicians have been adequately prepared to work with the dying patient and his family. As McCue[13] notes, even families with whom communication has been meticulous may turn on the physician in anger when the patient dies. This can severely traumatize the young physician. He may, in the future, seek to avoid open communication with both the dying person and his family, not only in his professional role but in his personal life as well.

With respect to the normal evolution of the sense of time and history in adulthood, the resident may find himself in an unusual position. His training may have so occupied his own time that he has reached his thirties or even forties without having dealt with a number of developmental tasks others came to terms with a decade earlier. While still concerned with the post-adolescent attempt to establish a professional identity, and to make his way in the outside world, the resident may find that other parts of his life—his family, his body, etc.—have changed in an almost Rip Van Winkle fashion, without his awareness. When he awakes, he experiences considerable distress. ◀

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Unstable Angina Pectoris After Myocardial Infarction

By Thanad Shay, M.D., Apichart L. Radee, M.D. and Rangson R. Ratan, M.D./Peoria

A patient with acute anterior wall myocardial infarction, complicated by left ventricular failure, and persistent post myocardial infarction angina pectoris, received intra-coronary streptokinase infusion followed by percutaneous transluminal coronary angioplasty. Improvement of the angina pectoris and cardiac hemodynamics were noted following successful coronary thrombolysis and reversal of the stenotic lesion.

This treatment may serve as a new alternative to emergency coronary artery bypass surgery in selected cases of acute myocardial infarction with suitable anatomic lesions.

Results of this study were first presented at a cardiac symposium on coronary artery disease held on October 22, 1983.

The patient with persistent or recurrent chest pain following a myocardial infarction, despite maximal medical management, presents a diagnostic and therapeutic dilemma to the practicing physician.

Chest pain following an acute myocardial infarction may indicate presence of viable ischemic myocardium surrounding a central infarcted zone. Interventions that increase oxygen supply or reduce oxygen demand can relieve chest pain and possibly maintain viability of the jeopardized myocardial tissue. Medical treatments including oxygen inhalation,[1] nitrates,[2-5] beta-blockade,[6-9] glucose insulin potassium solution[10-13] and intra-aortic balloon counter-pulsation,[14-19] may reduce myocardial ischemia and improve myocardial function.

When medical therapy is ineffective, some centers have performed coronary bypass surgery. However, in the setting of an acute myocardial infarction, morbidity and mortality may be higher. Two less invasive techniques are now coming into more common use. First, with the knowledge that acute myocardial infarction is commonly associated with an acute thrombotic occlusion of a previously sclerotic stenotic coronary artery,[20-22] thrombolytic therapy has been used. Intra-coronary streptokinase or plasminogen has been reported to recanalize coronary arteries and improve ischemic chest pain and left ventricular function.[23-32] The second technique is percutaneous transluminal coronary angioplasty. Here, coronary artery stenotic plaques are dilated with pressure from a balloon tip catheter. This technique has been reported to improve myocardial perfusion and angina pectoris.[33-35]

This report describes combined use of intra-coronary thrombolytic therapy followed by percutaneous transluminal coronary angioplasty. We feel this combination offers a potential alternative to emergency coronary bypass surgery.

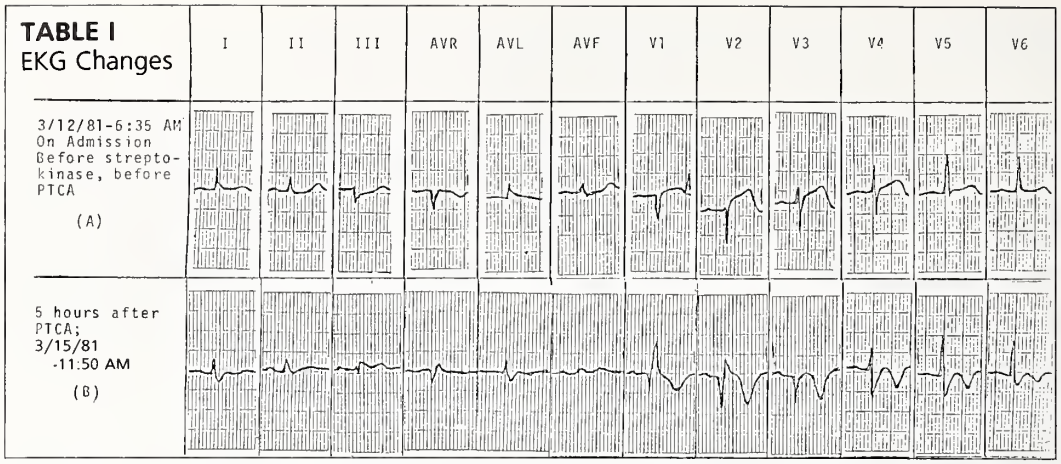
Description of Case

A 70-year-old semi-retired farmer was admitted shortly after being awakened by severe retrosternal chest pain radiating to the right shoulder and right arm.

Physical examination revealed a blood pressure of 140/90 and a regular pulse rate of 60. The patient was diaphoretic, cold and clammy. There were pulmonary basilar rales. Cardiac examination revealed an S-4 gallop at the apex. EKG and cardiac enzymes showed changes consistent with an acute anterior wall myocardial infarction. (Tables 1A and 2)

Initially, the patient was treated medically with propanolol 10mg orally every six hours and 2% nitroglycerin topical ointment two inches every four hours. Approximately six hours after the onset of persistent chest pain, he underwent emergency cardiac catheterization with selective coronary angiography.

TABLE I
EKG Changes



The left and right heart study showed moderate elevation of the left and right ventricular end diastolic pressure. (Table 3) Left ventriculogram showed anterior apical hypokinesis with an ejection fraction of 56%. (Figures 1 and 2) Right coronary angiogram showed a 30% stenosis in the proximal portion without any collaterals to the left anterior descending artery. Left coronary angiogram showed complete obstruction of the proximal left anterior descending artery after the first septal branch. (Figures 3A and B)

To ensure that the complete obstruction was not due to coronary artery spasms, 0.4 mg of nitroglycerin was infused into the left coronary artery without any response. After informed consent, (approximately 7½ hours after onset of the pain) a loading dose of 120,000 units of streptokinase was given I.V., followed by an infusion of 2,000 units per minute into the left coronary artery. After 45 minutes of infusion, the chest pain subsided completely. Two hours after infusion, repeat coronary angiography showed partial recanalization of the left anterior descending artery with evidence of a partially resolved thrombus. Following this, left coronary streptokinase infusion was continued at a rate of 1,000 units per minute for an additional four hours. Repeat left coronary angiography at six hours showed complete recanalization of the left anterior descending artery. However, there was still an 80% stenosis after the first septal branch with good distal runoff. (Figure 4)

Additional medications given to the patient included glucose insulin potassium solution (10% dextrose in water with 40 units of regular insulin, 40mq of potassium chloride at 40cc/hr.), low molecular weight dextran, 25cc/hr. and intravenous heparin, 1,000 units per hour.

24 hours after admission, the patient developed pleural pericarditic type of chest pain, along with pericardial friction rub. There was no neck vein distension, pulses paradoxicus or new heart murmur. Arterial blood gases showed a pH of 7.51, PCO2 of 27, PO2 of 48, CO2 content of 22 with an oxygen satu-

Figure 1
Before streptokinase. Left ventriculogram, right anterior oblique view; end diastole.

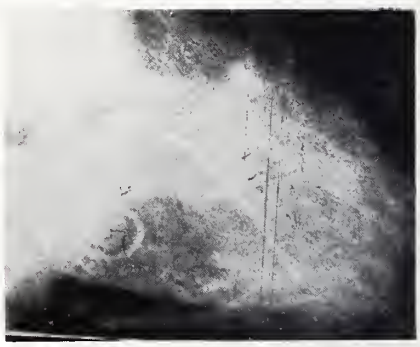


Figure 2
Before streptokinase. Left ventriculogram, right anterior oblique view; end systole. Anteroapical hypokinesis (arrow). Ejection fraction 56%.



TABLE 2
Changes of Cardiac Enzymes

	Total CPK 31-232	CPK MB <4%, <10U	Total LDH 100-190	LDH >70 MIU	SGOT 22-47 MIU/vol.
A. 3/12/81 06.40 hours	163	7% or 12U	153	36	59
B. 3/13/81 00.07 hours	1485	11% or 164U	478	252	418
C. 3/13/81 0700 hours	1190	9% or 112U	430	284	427

TABLE 3
Hemodynamic Data

	Pre/LVG		Post/LVG						
	AO	LVS/ LVEDP	AO	LVS/ LVEDP	EF	RA	RV	PA	PCW
A. 3/12/81 Before streptokinase		136/25	128/72 (98)	128/27	56%	9	41/13	41/22 (28)	21
B. 3/14/81 24 hours after streptokinase. Chest pain, LVF	160/63 (90)	136/28	128/74 (96)	128/31	47%	12	50/12	52/24 (36)	29
C. 3/15/81 5 hours after PTCA chest pain subsided LVF improved						10		37/14	12
D. 3/18/81		130/8		120/10	63%	4	28/7	28/7 (16)	5



Figure 3A
Before streptokinase. Left coronary artery, right anterior oblique view; complete obstruction of proximal left anterior descending artery (arrow).



Figure 3B
Before streptokinase. Left coronary artery, left anterior oblique view; complete obstruction of proximal left anterior descending artery (arrow).

ration of 88%. Emergency pulmonary perfusion scan showed no evidence of acute pulmonary embolus. Oxygen, intravenous furosemide and digoxin were given for heart failure. Low molecular weight dextran was reduced to 10cc per hour. Propranolol was stopped and never restarted. Despite the above interventions, there was no significant improvement of heart failure. Two hours later, the patient had recurrent severe persistent retrosternal chest pain. Emergency left coronary angiogram showed no recurrence of thrombotic occlusion, however, the right and left heart hemodynamics showed increased L.V. failure, and a decreased L.V. ejection fraction to 47%. (Table 3B)

After informed consent, emergency percutaneous transluminal coronary angioplasty of the left anterior descending artery was performed, using Gruntzig dilating catheter, 20mm. long and 3.7mm. in diameter. Dilating pressure was five atmospheres and the balloon was inflated for 15 seconds. Four successive dilatation attempts were made with complete abolition of the transtenotic gradient of 52mm.

A repeat left coronary angiogram showed a widely patent proximal left anterior descending artery. (Figure 5) There was marked improvement of the clinical status when chest pain subsided. Repeat right heart hemodynamics five hours later showed normalization of the mean pulmonary capillary wedge pressure. (Table 3C) Three days later, a repeat right and left heart catheterization showed normal right and left heart hemodynamics, (Table 3D) and the left anterior descending artery remained widely patent.



Figure 4
Six hours after intra-coronary streptokinase, before percutaneous transluminal coronary angioplasty. Left coronary artery, right anterior oblique view; complete recanalization of the left anterior descending artery with 80% stenosis of the proximal left anterior descending artery after first septal branch (arrow).

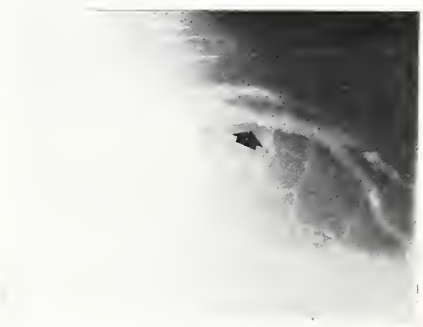


Figure 5
Immediately after percutaneous transluminal coronary angioplasty. Left coronary artery, right anterior oblique view; widely patent proximal left anterior descending artery (arrow).

Left ventriculogram was markedly improved with normal L.V. ejection fraction of 63% and mild residual anterior apical hypokinesis. (Figures 6 A and B)

Electrocardiogram done five hours post transluminal angioplasty showed evidence of anterior wall infarction with ST-T changes and transient right bundle branch block. (Table 1B) HIS bundle study showed mild prolongation of the HV interval (60 milliseconds).

The patient was anti-coagulated with dipyridamole, 50mg. four times daily and buffered aspirin, 650mg. twice daily. An attempt to use oral warfarin therapy was terminated due to lower gastrointestinal

Figure 6A

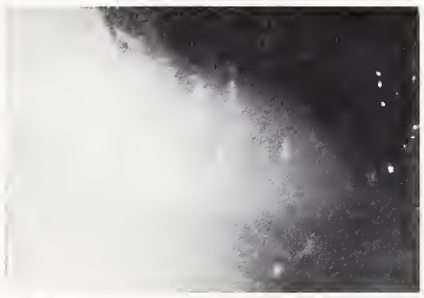


Figure 6B



Figure 6
A&B—Three days after percutaneous transluminal coronary angioplasty. Left ventriculogram, right anterior oblique view—(A. diastole) (B. systole) marked improvement of left ventricular contraction with ejection fraction 63%.

bleeding resulting from preexisting ulcerative colitis. He was discharged in good condition and remained asymptomatic and healthy to the time of this report. Repeat left coronary angiogram at three months showed the left anterior descending artery to be widely patent with further improvement of the left ventricular ejection fraction to 71%.

Discussion

We believe that the combined use of intra-coronary thrombolytic therapy followed by percutaneous transluminal coronary angioplasty is technically feasible with satisfactory benefits in a selected group of patients. That group includes those who present in the early phase of acute myocardial infarction with post myocardial infarction angina pectoris and left ventricular dysfunction, despite optimum pharmacological intervention. For them, this approach is a possible alternative to emergency coronary bypass surgery.

Our case demonstrated that successful intracoronary thrombolytic therapy and percutaneous transluminal coronary angioplasty can both improve left ventricular function and reduce myocardial ischemia. Our patient's heart failure was not improved by medical interventions which included digitalization, intravenous furosemide and cessation of propranolol therapy. The heart failure was probably not due to large myocardial infarction in this patient because the size of the infarct in this patient was relatively small on the basis of the peak CPK level (Table 2B), despite successful coronary thrombolysis. It was reported by others that the reperfused myocardial infarct has two to three fold peak CPK levels higher than the nonreperfused infarct of the same size.[23] The heart failure in this patient, despite the lack of recurring coronary thrombosis, was most likely due to large, viable ischemic myocardium with compromised function. The ischemia, which was due to severe residual artherosclerotic stenosis and lack of coronary collaterals, was also the cause of recurrent angina pectoris. Both the heart failure and ischemic chest pain were improved by successful coronary angioplasty. Our patient required several hours of intra-coronary streptokinase infusion to achieve thrombolysis because the streptokinase was started relatively late (7½ hours after the onset of symptoms of myocardial infarction). It has been reported that the later streptokinase therapy is iniated after the onset of symptoms of myocardial infarction, the longer the time required to achieve coronary thrombolysis.[31] However, the benefit was still possible when the streptokinase therapy was initiated 12-24 hours after the onset of chest pain.[32] This was probably due to the protective effect of the collateral circulation to allow a longer coronary occlusion with less myocardial necrosis.

We have successfully treated many other patients using this combined technique since this report. This combined technique should only be done in the hospital with the facilities for emergency coronary bypass surgery because the patient may need emergency coronary bypass surgery following unsuccessful coronary angioplasty. Because of possible reperfusion, ventricular arrhythmia following coronary thrombolysis, the patient should be prophylactically given lidocaine infusion. Fortunately, most reperfusion ventricular arrhythmias in man are benign, because the reperfusion is limited due to residual significant atherosclerotic stenosis. We did not encounter any significant reperfusion ventricular arrhythmia in this patient. He received licocaine infusion at the rate of 2mg per minute during and after coronary thrombolytic therapy and percutaneous transluminal coronary angioplasty. Because of the potential risk of serious ventricular arrhythmia associated with full reperfusion after coronary angioplasty in the setting of acute myocardial infarction, we feel that the angioplasty should be done 24 to 48 hours after the coronary thrombolysis. The optimum timing of coronary angioplasty following coronary thrombolysis for safety from serious reperfusion ventricular arrhythmia remains to be determined. Finally, the prevalence of coronary lesion following successful coronary thrombolysis suitable for transluminal coronary angioplasty remains to be determined. ◀

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A complete set of references for "Post Myocardial Infarction Unstable Angina Pectoris," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

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Referral Patterns Among Family Practitioners

By Fred Z. White, M.D., M.A. (Ed.)/Chillicothe

It's been said that the family doctor takes care of 80 to 95% of the patients that he sees and refers the rest for consultation or treatment. Because of the very wide range, it would seem that hard data are not readily available. For planning purposes it would be helpful to know which of the other specialties are utilized by family physicians and to what degree they are utilized for referrals and consultations. This study of practices involved with a family practice residency was undertaken for that purpose.

For a period of one month, six practices involved with our teaching program were monitored for the number of encounters and the referrals that occurred. There were 12 physicians in private practices involved in this study, plus residents in an outpatient facility, which was calculated as equivalent to five full-time physicians. This combination of participants brought the total number of physicians in the study to 17.

The number of patient encounters during this month of study ranged from 131 to 545 per physician per month, with an average of 234 encounters per month per physician, including the family practice residency.

The consultation rate by practice ranged from a low of 0.82% to a high of 4.42%. The high rate of consultations was in the outpatient center, where one would expect this greater rate of referral with the family medicine residents.

The average consultation rate for the total study population in all of the practices was 2.9% (See Table 1).

To test the validity of these rates, a second study was performed six months later with the same practices. Again, the same statistics were kept for a period of one month. The average referral rates for consultations compared with the initial study are shown in Table 1-A. The overall consultant referral rate is quite consistent in the two samples. The range in the second sample was 1.73% to 3.42%, which also compared favorably and speaks to the validity of these conclusions.

Specialty Referrals

Twenty-one different specialties were consulted by the physicians involved in this study. Of the outpatient consultations requested, ENT was the most frequent and represented 15.3% of the total, with surgery and neurology representing 11.86% each of the total, and still other specialties representing a proportionately smaller group (See Table 3).

In the second month sampled there were some variations from the first sample in the sequential rates and percentages of referrals to various specialties for consultations. This is shown in Table 3-A. However, in both studies the most common disciplines consulted (*i.e.*, ENT, surgery, neurology, orthopedics, OB/GYN, and dermatology) remain consistent.

Referrals for X-ray for the total population represented a referral rate of 6.72%, while lab had a referral rate of 13.3%. Other special

Table 1
Office Encounters

Practice	# of MD's	Total Patient Visits	Referrals: Consultation #	Consultation %	X-ray	Laboratory	Other
A	4	820	24	2.92%	63	265	106
B	5	882	39	4.42%	96	216	31
C	3	970	19	1.95%	57	N/A	10
D	1	364	3	0.82%	19	37	6
E	3	394	17	4.31%	24	12	7
F	1	545	16	2.93%	8	N/A	2
Totals	17	3,975	118	2.97%	267 (6.72%)	530 (13.3%)	162 (4.08%)

Table 1-A
Office Encounters

Practice	# of M.D.'s	Total Patient Visits	Consultation #	Consultation %	Previous %
A	4	806	18	2.23%	2.92%
B	5	1,050	36	3.42%	4.42%
C	3	970	19	1.95%	1.95%
D	1	345	6	1.73%	0.82%
E					4.31%
F	2	776	12	2.44%	2.93%
G	2	603	16	2.65%	
Totals	17	4,550	107	2.35%	2.97%

268 Pts./M.D./month
234 Pts./M.D./month (previous study)

Table 2
Hospital Encounters

Practice	MD's	Patient Days Sole Care	Patient Days Shared Care With Consultant
A	4	132	11
B	5	193	33
E	3	67	1
F	1	165	59
Totals	13	557	104

Represents: 42.85 days per M.D. (Family Practice)
8 days of shared care per M.D.

services for which referrals were made, such as Holter monitoring and stress testing, represented a 4.08% referral rate (See Table 1).

There was a rather wide range in regard to referrals for X-ray, lab, and other services that depended on the specific office X-ray or lab capabilities, and possibly to the distance from the hospital for the individual practice locations.

The impact of these practices on hospital admissions and on consultant utilization within hospitals was a little harder to determine, since some of these practices were quite distant. However, the four practices that did utilize our medical center found a total of 13 family physicians involved with 557 hospital days utilized for an average of 42.85 days per month per family physician in the study. There were 104 consultant days used in this 557 days. Calculated in the same way, this would be eight consultant days per physician per month (See Table 2).

Examining the consultation patterns in the hospital revealed a different specialty utilization pattern than in the outpatient study (See Table 3). Of the admitted patients on whom consultations were sought, the numbers of days of care with surgeons was the greatest, as 29.8% of the consultant days included concurrent surgeon care. Cardiology was second with 17.3% and psychiatry was third with 16.3%. Others in decreasing order of frequency were: physiotherapy and GU, orthopedics, OB/GYN, ENT, and to a much lesser extent, GI, pulmonary and hematology.

Summary

In an earlier study done in 1971, physicians in the community were studied in a somewhat similar way. At that time, prior to any involvement with a teaching program, the referral rate was 0.6% from physicians' offices to other consultants. It must be realized that at the time the number of consultants available, particularly in subspecialties was much smaller.

Given the number of consultants and subspecialists available now, this current outpatient referral rate averaged 2.97%. This compares favorably with the national referral rate of 3.4% as identified in the Robert Wood Johnson Foundation Study.[1] Consultants, in addition to the outpatient consultations received from family physicians, also received considerable consultative work within the hospital. This amounted to eight consultant days per physician or over 90 consultant days per year per family physician.

Table 3
Frequency of Consultations

Specialty	Outpatient	Inpatient
ENT	15.3%	1.92%
Surgery	11.86%	29.8%
Neurology	11.86%	—
Orthopedics	8.47%	5.76%
Ophthalmology	6.78%	—
Gynecology	5.08%	4.8%
Obstetrics	5.08%	4.8%
Cardiology	4.23%	17.3%
Physical Therapy	4.23%	8.65%
G.U.	3.39%	8.65%
Pulmonary	3.0%	—
Dermatology	3.0%	—
Psychiatry	—	16.3%
G.I.	—	1.92%

Table 3-A
Frequency of Consultations

Specialty	Study I Rank	Study I %	Study II Rank	Study II %
E.N.T.	1	15%	4	11%
Surgery	2	12%	2	14%
Neurology	3	12%	3	12%
Orthopedics	4	8%	4	11%
Ophthalmology	5	7%	6	7%
OB/GYN	6	5%	1	22%
Cardiology	7	4%	12	2%
Physical Therapy	8	4%	—	—
G.U.	9	3%	7	6%
Pulmonary	10	5%	—	—
Dermatology	11	3%	8	5%
Psychiatry	—	—	9	4%
G.I.	—	—	10	3%

The frequency of consultants used displays a different pattern in the inpatient and outpatient area. For outpatient consultations, ENT, surgery, and neurology are the disciplines more frequently utilized. Within the hospital, the disciplines more frequently utilized are surgery, cardiology, and psychiatry. These data are not truly comparable because in the outpatient consultation there is a single encounter we are measuring while within the hospital, it is days of hospitalization that were counted. It is likely that surgery, cardiology, psychiatry, physical therapy and GU represent the longer lengths of stay.

The rate of consultations in patient days hospitalized is 18.67% within the hospital. This would indicate that family physicians, even in a teaching program where consultations for the purpose of teaching are more likely to be sought than in a private practice, continue to take care of most of the needs of their patients in the hospital as well as in the office setting. ◀

References

1. The Robert Wood Johnson Foundation, (Special Report): MEDICAL PRACTICE IN THE UNITED STATES, Figure 2.6, page 28 and 29, 1981.

Fred Z. White, M.D., M.A. (Ed.), is a diplomate of the American Board of Family Practice and a fellow of the American Academy of Family Physicians. An associate professor at the University of Illinois College of Medicine in Peoria, Dr. White is also an adjunct professor of education at Bradley University. He is a member of the board of trustees of the Methodist Medical Center of Illinois, Peoria, where he serves as associate director for the Family Practice Residency Program and is a former president of the active medical and dental staff.

An ISMS past president, (1981-82) Dr. White is presently chairman of the board of governors for the Illinois State Medical Inter-Insurance Exchange. A former ISMS trustee, he is a past president of the Peoria Medical Society, Peoria Tazewell Heart Association, Illinois Heart Association, Peoria Board for Medical Education and Midstate Foundation for Medical Care.

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Obituaries

****Bubolz, Richard C.,** Manteno, died May 20, 1984 at the age of 83. Dr. Bubolz was a 1929 graduate of the Northwestern University Medical School, Chicago.

****Croft, Joseph D.,** Evanston, died May 24, 1984, at the age of 81. Dr. Croft was a 1931 graduate of Northwestern University Medical School, Chicago.

***Farrar, Holden K.,** Evanston, died June 5, 1984 at the age of 59. Dr. Farrar was a 1948 graduate of Northwestern University Medical School, Evanston.

****Foley, Edmund F.,** Crystal Lake, died May 4, 1984 at the age of 86. Dr. Foley was a 1921 graduate of Rush Medical College, Chicago.

****Lewis, Elbert K.,** died May 12, 1984 at the age of 74. Dr. Lewis was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

***McGuire, Francis H.,** Evergreen Park, died June 5, 1984 at the age of 83. Dr. McGuire was a 1929 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Moisant, Bernard E.,** Aurora, died April 21, 1984 at the age of 72. Dr. Moisant was a 1939 graduate of the University of Illinois College of Medicine, Chicago.

***Quinn, William P.,** Chicago, died May 29, 1984 at the age of 74. Dr. Quinn was a 1937 graduate of the Meharry Medical College School of Medicine, Nashville.

****Ranson, Gilbert T.,** Fairfield, died April 4, 1983. Dr. Ranson was a 1935 graduate of the Vanderbilt University School of Medicine, Nashville.

****Ritter Israel I.,** Chicago, died May 13, 1984 at the age of 84. Dr. Ritter was a 1931 graduate of Rush Medical College, Chicago.

***Samet, Eli T.,** Wilmette, died May 20, 1984 at the age of 62. Dr. Samet was a 1950 graduate of the Northwestern University Medical School, Chicago.

***Young, Francis J.,** Palos Heights, died May 17, 1984 at the age of 75. Dr. Young was a 1937 graduate of the University of Illinois College of Medicine, Chicago.

Zubrick, Bruno E., Chicago, died May 4, 1984 at the age of 44. Dr. Zubrick was a 1965 graduate of the Baylor College of Medicine, Houston.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Legal Considerations of Medical Staff Bylaws

The Illinois State Medical Society has prepared "Legal Considerations of Medical Staff Bylaws," as an educational service for its members. This document is an appendix to the "ISMS Guide to Hospital Medical Staff Bylaws," published in the April-June issues of IMJ.

This publication deals with several topics which are currently of particular importance to medical staff bylaws committees and to physicians in general. Special emphasis is placed upon questions relating to the appointments process and disciplinary proceedings. The purpose of this appendix is to provide the reader with a general discussion of some of the key points in this complex and rapidly changing area of the law.

The development of this document was a project of the Council on Medical Services, in cooperation with ISMS legal counsel.

This publication does not constitute legal advice, and the reader should never treat it as such.

Copies of the complete document and this appendix will soon be available upon request from ISMS. There is also a bibliography available which gives references to more comprehensive works in this field, some of which remain current through continual distribution of revisions containing recent developments.

The bylaws of a medical staff are an important mechanism for structuring the practice of medicine in a hospital. They define both legal and organizational relationships between individual physicians, committees, the medical staff as a whole, the governing body, and the administration. The topics that follow discuss some of the important legal issues which should be considered when examining medical staff bylaws for private hospitals. The vast majority of Illinois hospitals are private, and therefore this document does not discuss the law as it applies to public hospitals. Readers interested in public hospitals should consult the Illinois Institute for Continuing Legal Education publication, *Representing Health Care Institutions* (1980).

Because the scope of this work is limited, and due to the rapid rate of change in the subject matter, specific questions or problems should always be discussed with legal counsel. This document does *not* constitute legal advice, and the reader should never treat it as such. Neither should it be deemed as setting any standard or requirement. The importance of discussing specific problems with legal counsel cannot be overemphasized. Medical law is constantly changing, and only knowledgeable counsel can provide complete, up-to-date answers to questions in this field. The reader should also understand that the article attempts to give only a broad overview of several issues, and there are many topics relating to medical staff bylaws which are not covered.

I. An Introduction to Due Process

The medical staff bylaws set forth the procedures for processing applications for membership on the staff, reappointment to the staff, delineation of clinical privileges, and reduction or termination of privileges and membership. These procedures are of critical importance because of their impact on the quality and composition of a medical staff. The determinations of staff membership and clinical privileges are of great economic significance to physicians. Compliance with the law in this area is necessary to prevent litigation by those affected by adverse decisions.

The issue which continually is at the center of such litigation is whether the medical staff and the hospital afforded the complaining physician due process in the appointment, reappointment, or corrective action process. Due process is a concept which has different meanings in different contexts, but basically due process means fairness. The procedures must be fair, and the rules being applied in the proceedings must be fair.

Complexities arise in determining how much fairness is required in a particular situation. That may depend on whether the hospital is public or private. The fact that a

dispute grew out of proceedings for initial application for staff membership, rather than reappointment, will affect how much due process is required. The due process rights of the individual may be derived from the federal or state constitutions, common law, or the bylaws themselves.

II. Due Process Considerations in the Processing of Initial Applications for Medical Staff Membership.

A. The Federal Courts' Due Process Nexus Test

The fourteenth amendment of the U.S. Constitution provides that a state may not deprive a person of life, liberty or property without due process of law. The fifth amendment of the U.S. Constitution has been interpreted to apply the same due process standard to actions by the federal government. The Illinois constitution provides that no person shall be deprived of life, liberty, or property without due process of law. The Illinois provision has been interpreted to apply only to action by a state entity.[1]

Plaintiffs in various contexts have claimed that constitutional due process requirements are applicable to private hospitals. Membership on a medical staff is of sufficient economic importance to be considered a property interest. Therefore, any state action to deny or take away that property interest is subject to constitutional due process requirements. Plaintiffs have argued that the extensive state regulation of a hospital, combined with the receipt of funds from various governmental sources, is sufficient to characterize all conduct of the hospital as "state action".

The United States Court of Appeals of the Seventh Circuit has rejected such a theory of state action. The court has held that acceptance of government funds by a private institution which is heavily regulated by government does not necessarily mean that the conduct of the institution can be characterized as "state action". There will be "state action" only if there is a nexus, or link between the governmental regulation or funding and the actions of the institution being challenged by the plaintiff.[2]

"State action," which would subject a private institution to federal constitutional due process requirements, will exist only if the state affirmatively supports and is directly involved in the specific conduct which is being challenged.[3] Barring a finding of "state action," there is no requirement that private hospitals comply with the federal constitutional due process requirements, and a federal court will not review such action by a private hospital.

B. Illinois Courts: Due Process Requirements Are Uncertain

The case of *Mauer v. Highland Park Hospital Foundation,* 90 Ill. App.2d 409 (1967), established the principle that the rejection by a private hospital of an application for membership on the medical staff will not be subject to judicial review by Illinois courts. In that case, the court held that receipt of public funds combined with extensive government regulation does not constitute "state action." Therefore, the plaintiff had no cause of action based on the federal or state constitutional due process provisions. The court refused to establish a common law rule of due process, in part because the principles of *Darling v. Charleston Memorial Hospital,* 33 Ill. 2d 326 (1965), create the possibility that hospitals may be liable for careless selection of staff members. *Jain v. Northwest Community Hospital,* 67 Ill. App. 3d 420 (1978) and *Mennes v. South Chicago Community Hospital,* 100 Ill. App. 3d 1029 (1981) re-affirmed the *Mauer* doctrine of nonreview.

Although *Mauer, Jain* and *Mennes* allow a private hospital to reject application for staff membership for any reason and to not disclose to the applicant the reason for the rejection, these precedents were decided by appellate courts. The question has not been addressed by the Illinois Supreme Court. Decisions in other states (New Jersey, Arizona, and California) have ruled that applicants for staff membership are entitled to due process and that the courts will review the application process of private hospitals.

The Illinois Supreme Court in *Van Daele v. Vinci,* 51 Ill. 2d. 389 (1972), has applied principles of due process to expulsion proceedings of a private association. (*Van Daele* will be discussed in more detail in the section on disciplinary proceedings.) There is one Illinois case, *Treister v. American Academy of Orthopaedic Surgeons,* 78 Ill. App. 3d 746 (1979), which seems to acknowledge the validity of the *Mauer* rule, yet applies a contrary rule in a similar situation. The *Treister* court held that it would "review the application procedures of a private association when membership in the organization is an economic necessity." *Treister,* 78 Ill. App. 3d 746, 755.

A further factor that should be considered in evaluating whether to grant due process rights to initial applicants for medical staff privileges is a requirement promulgated by the Illinois Department of Public Health pursuant to Section 10(c) of the Illinois Hospital Licensing Act (*Ill. Rev. Stat.,* Ch.111-½, Sec.151(c). The requirement regarding medical staff states as follows at Sec.3-1.1:

1. The medical staff shall be organized in accordance with written bylaws, rules and regulations, approved by the Governing Board. The bylaws, rules and regulations shall specifically provide but not be limited to the following provisions:

 (a) for written procedures for accepting and processing applications for medical staff membership which shall include verification of current license in Illinois and biennial review of renewed license;

 (b) for eligibility for staff membership, whether the practitioners are or are not currently members of the medical staff;

 (c) for a policy that specifies a procedure for processing applications for staff privileges and guarantees due process and fair hearing for each such applicant;

In a recent Opinion Letter the Illinois Attorney General has stated that Sec. 3-1.1 mandates that a licensed hospital afford due process to each applicant for medical staff membership. *Op. Atty. Gen. 84-004* (1984). In the Attorney General's Opinion, applicants should be afforded the following due process safeguards: reasonable notice; the opportunity to appear and be heard, both in person and by counsel; the opportunity to present and examine evidence; and the opportunity to present and cross-examine witnesses. Although an

Opinion Letter is not binding on an Illinois court, it may prove persuasive.

Notwithstanding the Opinion of the Attorney General, an argument may be made that the foregoing requirement does not mandate providing due process to initial applicants for medical staff membership. Section 3-1.1(a) and (b) explicitly apply to "staff membership." However, Sec. 3-1.1(c) refers only to due process regarding applications for "staff privileges." If the Department of Public Health had intended Sec.3-1.1(c) to apply to applications for "staff memberships" it could have used that terminology, as it did in Sec. 3-1.1(a) and (b). Thus, Sec. 3-1.1(c) can be interpreted to apply only to physicians who are already on staff and are going through annual or bi-annual delineation of privileges, not to initial applications for "staff membership." This conclusion is further supported by the fact that Sec. 3-1.1(c) has never been mentioned in any reported judicial decision regarding due process for initial applications for medical staff membership.

The Joint Commission on Accreditation of Hospitals (JCAH) also distinguishes between the due process protections available to existing staff members as opposed to applicants.

In the current and the 1985 edition of the JCAH Accreditation Manual for Hospitals (AMH), Standard II, Section D(2) of the medical staff chapter requires that bylaws include: "Fair-hearing and appellate review mechanisms, which may differ for medical staff members and other individuals holding clinical privileges and for applicants for such membership or privileges."

The JCAH *AMH* is distributed on a national basis and not tailored to the law of Illinois. However, the *AMH* does indicate that a hospital should employ at least minimal procedural protections to new applicants.

The conclusion to be drawn is that although a private hospital may not be required to provide any due process to an applicant for staff privileges, decisions in other states and Illinois offer rejected applicants enough hope to continue to litigate the validity of the status quo. Therefore, a medical staff should discuss with legal counsel whether it is appropriate to provide some level of due process to applicants.

The full range of due process options includes, but is not limited to: (1) no notice of the reasons for denying the applicant's request; (2) written notice of the reasons for the denial of the application; (3) opportunity to ask for a limited hearing; and (4) full hearing and appeal rights.

III. Due Process Requirements in Disciplinary Proceedings

A. Some Degree of Due Process is Advisable

Van Daele v. Vinci, 51 Ill. 2d 289 (1972), established the rule that Illinois courts will review the disciplinary proceedings of private associations which affect "an important economic interest" of a member to determine whether the association provided a hearing before a fair and impartial tribunal. The private association in *Van Daele* was a retail grocer's association. The court indicated that private organizations "tinged with public stature or purpose" would be subject to such review.

Because staff membership and level of clinical privileges are "important economic interests," and because health care providers are "tinged with public stature or purpose," private hospitals may be subject to judicial review in matters concerning reduction or termination of a member's privileges. However, a recent Illinois Appellate decision, *Maimon v. Sisters of The Third Order,* 120 Ill.App.3d 1090 (1983), recently affirmed the rule that a court should not act to annul a private hospital's disciplinary proceedings unless unfairness is demonstrated by 1) the fact that the hospital failed to follow the constitution or by-laws of the hospital, or 2) the record of the proceedings clearly established bias on the part of the decision making body. *Van Daele* was viewed as merely establishing the latter of the "exceptions" applicable to private associations.

B. Elements of Due Process

1) *A disciplinary procedure need not be conducted with all the due process mechanisms of a trial court.*

The *Van Daele* court recognized "that strict adherence to judicial standards of due process would be arduous and might seriously impair the disciplinary proceedings of voluntary associations. . ."[4] Although the court did not spell out the minimum level of due process in such proceedings, it is clear that a hospital does not have to stage an elaborate hearing with all the trappings of a trial.[5] The court in *Ladenheim v. Union County Hospital,* 76 Ill. App. 3d 90,96(1979), noted that due process is a flexible concept, the requirements varying "with the circumstances to which it is applied, because no particular mode of procedure is mandated."

2) *A hospital must follow its own bylaws.*

Illinois courts have held that in conducting a disciplinary action a "hospital must follow its own bylaws. . ." *Nagib v. St. Theresa Hospital, Inc.* 41 Ill. App. 3d 970 (1976). In that case, both the hospital and the physician who had been dismissed from the medical staff agreed that the bylaws must be followed. The issue was how the bylaws should be correctly interpreted. The court concurred with the physician's interpretation. See also, *Maimon v. Sisters of The Third Order,* 120 Ill.App.3d 1090 (1983).

Hospitals should examine their bylaws with *Nagib* and *Maimon* in mind. Because of the serious nature of disciplinary proceedings, it is very important that the procedures be stated with clarity.

3) *Decision makers should be impartial.*

Due process requires that the decision makers at the hearings be impartial. This rule was established in the *Van Daele* case, which involved a hearing board consisting of persons who were defendants in litigation brought by the members who were being expelled. In addition, the record reflected personal animosity between the hearing board members and those being expelled. The court held that the bias of the hearing board prevented the board from providing the fair and impartial hearing required by due process.

Ladenheim v. Union County Hospital, 76 Ill. App. 3d 90 (1979) discussed the issue of bias in a case which involved disciplinary action by a public hospital. The due process rights of a public hospital are derived from the federal and state constitutions, and give the staff member the broadest possible protection. In *Ladenheim,* a physician, Dr. R., who sat on the credentials committee at a disciplinary hearing, had assisted the hospital attorney who was preparing charges against Dr. Ladenheim by interpreting a memorandum from the director of nurses. Dr. Ladenheim charged that Dr. R.'s presence on the credentials committee violated the due process requirement of an impartial tribunal. The court rejected Dr. Ladenheim's contention by stating:

> . . . due process does not require that every member of an administrative tribunal be completely unfamiliar with the factual issues presented at a hearing, the only bias and familiarity which disqualifies a member of the tribunal is that which derives from an extrajudicial source and which results in an opinion on the merits based on something other than that which was learned from participation in the case. Mere involvement in the preliminary procedures required to bring the case to a hearing is not equivalent to unacceptable bias and familiarity (*cites omitted*). In administrative proceedings, combination of investigative and adjudicatory functions does not violate due process unless actual personal bias results and is demonstrated in the record.

The *Ladenheim* court also addressed the question of whether the hospital attorney could both examine witnesses (a prosecutorial function) and advise the credentials committee on legal aspects of various motions made by Dr. Ladenheim (a judicial function). The court held that this was not a violation of due process in such an administrative hearing.

Finally, *Ladenheim* pointed out that generally the final arbiter in the disciplinary proceeding should not have participated in making the decision under review. See also, *Goldberg v. Kelly,* 397 U.S. 254 (1970); *Kraut v. Rachford,* 51 Ill. App. 3d 206 (1st Dist, 1977); *Maimon v. Sisters of The Third Order,* 120 Ill.App.3d 1090 (1983). (Physician who helped formulate disciplinary charges against a staff member and also sat on the reviewing committee held not to have violated hospital by-laws prohibiting "active participation" in both proceedings. The court noted that the physician sat on the reviewing committee only as a non-voting *ex officio* member and that he had made only a few peripheral statements on record during the hearing.)

4) *Physicians alleged to have violated the bylaws should be given written notice of charges and hearing date, and they should be allowed to present and examine witnesses and evidence.*

The court in *Ladenheim* did not define the minimum due process requirements for disciplinary proceedings. It did, however, describe the Union County Hospital's process as "sufficient." The process consisted of ". . . notice, a hearing before an impartial tribunal, representation by counsel, opportunity to cross examine witnesses and to present evidence, and the opportunity to inspect documentary evidence against him."[6]

Due process requirements will be satisfied if a procedure in the bylaws gives a staff member who faces a possible reduction or termination of privileges, the respondent, an opportunity to prepare for and participate in a fair hearing before an impartial tribunal. In order to adequately prepare for a hearing, a person should receive written notice of the specific problems, issues, or charges to be considered, as well as the disciplinary action which may be taken. Such notice should be given to the respondent well in advance of the hearing date. The notice should include information as to dates and specific incidents which are grounds for the hearing.

The procedures for a hearing should be consistent with its purpose, which is basically one of fact finding. The adversarial court room model can waste enormous amounts of time as well as generate needless animosity. The respondent should always be given the opportunity to question witnesses, present evidence, and inspect and challenge evidence. Courtroom rules of evidence are not appropriate for a hearing of a credentials committee or a governing body, as the application of such rules would be a constant source of conflict and debate. The bylaws should set out a reasonable rule as to what evidence will be considered.

5) *The issue of whether a respondent has a right to have counsel present at a disciplinary hearing is not settled in Illinois.*

Since Illinois courts have not addressed the issue of whether there is a right to counsel at a disciplinary hearing, the issue has not yet been settled in Illinois, and medical staffs should continue to consider the option of excluding attorneys from such hearings.

The majority of cases in other jurisdictions find a right to counsel,[7] and some commentators have stated that a right to counsel should be afforded a respondent in Illinois.[8]

The main reason for excluding them is that attorneys have an inclination to convert what should be a discussion focused on fact finding into a battle of words over technicalities. However, fairness requires that if the hospital attorney is present, the respondent should have a right to counsel.

IV. Qualifications to be a Member of a Medical Staff

Almost all of the criteria for staff membership discussed in this section are based on factors which may change at some point after a physician has been admitted to a medical staff. For example, although a physician may meet a residency requirement when he applies for staff membership, it is possible that several years later he will move to a location which violates the requirement. Although a decision by a private hospital to reject an applicant for staff membership based upon a residency requirement would not be subject to judicial review, a decision to expel a current member for violation of the requirement would be reviewable by a court. Any requirement in the bylaws subject to judicial review must be essentially fair in order to be upheld by the court. Therefore, all qualifications which are arbitrary, irrational, or discriminatory are not appropriate.

All qualifications for staff membership should be clearly stated in the bylaws. They should be applied uniformly and consistently.

A. Residency Requirements

A medical staff may wish to require that all staff members have a residence which is close enough to the hospital to allow the physician to provide continuous care to patients he admits to the hospital. Such a requirement, if properly drafted and applied, is a legitimate condition for staff membership.

Sams v. Ohio Valley General Hospital Association, 413 F. 2d 826 (4th Cir. 1969) gives an example of a residency requirement which is not valid. In that case, all physicians on the staff were required to have their offices and practices in Ohio County. The Fourth Circuit Court of Appeals struck down the requirement as being arbitrary. A political boundary such as a county line can be arbitrary because some parts of a county may be much further from a hospital than are others.

A residency requirement is justifiable if it is a means of providing better patient care, *i.e.*, its goal is to establish an acceptable response time by an admitting physician to the medical crises of his patients. Therefore, the only proper standard to apply to the residence of a physician is whether the physician can travel to the hospital from his residence under normal weather conditions within a set amount of time. It is not appropriate to use political boundaries or geographic distance to mark the outer limits, because those criteria will rarely result in a uniform travel time. The appropriate time to respond to a medical emergency should not vary from physician to physician, and, therefore, the requirement should be uniform for the entire medical staff.

B. Board Certification

Board certification is one measurement of a physician's qualifications and it is appropriate to consider that as a factor when processing an application for staff membership and when granting privileges. In light of the Medicare condition at C.F.R. 42, Sect. 405.1023(e)(4) which states that, "Under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society," the requirement of board certification for all physicians on staff may not be legally defensible. By not using board certification as a requirement for staff membership, a medical staff will be better able to avoid the problem of delegating the credentialling process to outsiders. It is important that the credentials committee conduct a thorough enough investigation to ascertain for itself the level of skills a physician can bring to the medical staff.

The use of board certification as a condition for medical staff membership raises the possibility that a physician who is removed from a medical staff because a new bylaw requires board certification might litigate the dismissal if he has offered evidence that he is as skilled as those physicians who are board certified.

The court in *Armstrong v. Board of Directors of Fayette County,* 553 S.W. 2d 77, (1976) found that a bylaw requiring board certification resulted in "the board of directors closing their minds to the competency" of the applicant. The court held such action to be "arbitrary, capricious (and) discriminatory," and held the bylaw to be invalid. The Ohio Supreme Court reached an opposite result in *Kahn v. Suburban Community Hospital,* 340 N.E. 2d 398 (1976).

Kahn held that a court should not substitute its judgement for that of the governing board of the hospital in the area of determining the qualifications for clinical privileges, and upheld a hospital's decision to deny major surgical privileges to a physician who did not meet at least one of the following criteria:

(1) Board certification in the specialty covering the privileges desired;
(2) Board eligibility in the specialty covering the privileges desired, verified by submission of an approved application to take the appropriate board examination and certification to be obtained within five years of the member's initial appointment to the staff unless additional time is granted by the medical staff executive committee;
(3) Fellowship in the American College of Physicians or Surgeons; or
(4) A minimum of ten years of experience as an attending physician or surgeon in the specialty covering the privileges desired, such experience to be approved by the Medical Staff Executive Committee of Suburban Community Hospital and certified by them to the Board of Trustees of Suburban Community Hospital.

These issues should be discussed with the hospital's legal counsel. It may be that the safest policy to adopt is one which is expressed in the JCAH manual on accreditation: "Specialty board certification or current eligibility as defined by the appropriate board is an excellent benchmark for the delineation of clinical privileges. . . ."

The "benchmark" approach acknowledges that board certification is relevant to, but not the sole determinant of the qualifications of a physician.

C. Malpractice Insurance

Some hospitals require that physicians who are on the medical staff carry malpractice insurance. There are no reported decisions of Illinois courts on the validity of such requirements, but several recent cases in other states have upheld insurance requirements.[9]

In *Renforth v. Fayette Memorial Hospital,* 383 N.E. 2d 368 (Ind. App. 1978), the court held that the insurance requirement was not irrational or arbitrary. The hospital gave the following reasons for its rule:

(1) If both hospital and a physician were named defendants in a lawsuit, the hospital desired assurance that the physician could contribute towards costs of defending against such an action;
(2) The hospital felt it was showing due regard for patients it serves by requiring insurance coverage for the doctors who might become liable to the patients;
(3) By imposing the requirements on the physicians who used the hospital's facilities, the hospital was in a better position to assure insurance coverage for itself, and at a lower premium, and
(4) The hospital feared that it might suffer the financial burden for negligence committed in its emergency room by a member of the medical staff if that physician had no insurance.

D. Ability to Work with Others

There being no reported Illinois cases on this issue, an examination of case law in other states reveals variations upon a basic theme. While most recent cases agree that the existence of conflict between members of a medical staff can be detrimental to the quality of patient care, there are different standards that have been applied to the issue of how much evidence a hospital must present of specific instances of lower quality patient care caused by the inability of a physician to work with others.

In *Miller v. Eisenhower Medical Center,* 614 P. 2d 258 (1980), the California Supreme Court upheld the requirement that applicants to the medical staff of a private hospital must be able to document their "ability to work with others" in order to assure high quality patient care. The court remanded the application to the hospital, with instructions that the bylaw be interpreted:

> . . . to preclude the rejection of an otherwise qualified physician from medical staff membership unless it can be shown that he manifests an inability to "work with others" in the hospital setting, which by reason of its particular character, presents a real and substantial danger that patients treated by him at the facility might receive other than a "high quality of medical care" . . .

The thrust of the *Miller* opinion was that a physician may not be denied staff membership for being "controversial, outspoken, abrasive, hypercritical, or otherwise personally offensive" unless the hospital proves that the individual's characteristics would post a "realistic and specific threat" to the quality of patient care.

In *Huffaker v. Bailey,* 540 P. 2d 1398 (1975), the Oregon Supreme Court upheld the rejection of an applicant to a private hospital's medical staff on the basis of a bylaw requiring documentation of ability to work with others. The court used a standard that required only, ". . . a basis for a doubt that petitioner was able to work well with others."

In contrast to the interventionist posture of the California court in *Miller,* the court in *Huffaker* discussed the need for judicial restraint in challenges to decisions by boards of directors of private hospitals.

Illinois medical staffs can practice preventive medicine by checking their bylaws to see whether any "ability to work with others" requirements explicitly state the patient care justification for the rule. If a hospital ever applies such a bylaw, it is important that it document, with as much specificity as possible, incidents of objectionable physician behavior and the detrimental impact of that behavior on the quality of patient care.

E. Closed Staff Due to High Rate of Hospital Occupancy

A hospital which is experiencing an occupancy rate which is close to 100% may not be able to provide optimum care to patients in its service area. Some patients might experience delays of several days or more before being admitted, and others might have to be admitted to a different hospital and treated by a physician other than the one of their choice, if that physician does not have privileges at the other hospital. In addition, there may be pressures to discharge patients prematurely in order to open up beds for those awaiting admission.

One possible response to such a situation would be for the hospital board of directors to state to all applicants for medical staff membership that no further appointments would be made to the medical staff until the occupancy rate declines.

While there are no reported cases in Illinois addressing the validity of such a rule, the Supreme Court of New Jersey upheld a closed surgical staff decision in *Guerro v. Burlington County Memorial Hospital,* 360 A. 2d 334 (1976). The court held that the rule was a reasonable effort by the hospital to maintain high quality patient care.

As was discussed in greater detail in section IIB, *Mauer v. Highland Park Hospital Foundation,* 90 Ill. App. 2d 409, (1967) established the rule that Illinois courts will not review a hospital's rejection of an initial application for staff membership to determine whether due process was afforded. If *Mauer* retains it validity it is unlikely a court would review an applicant's complaint that a closed staff rule was unreasonable, arbitrary, or capricious.

If an applicant could prove that a hospital's closed staff rule was implemented with the goal of protecting the economic interests of the current medical staff members and was unrelated to patient care considerations, he might have a cause of action under federal or state anti-trust laws. A discussion of anti-trust law in the health care field is beyond the scope of these guidelines, and counsel should be consulted about the anti-trust considerations of a specific closed staff rule. To avoid anti-trust problems, the patient care justifications of a closed staff rule should be documented by the board of directors and the patient care justification should be stated in the rule.

F. Continuing Medical Education

The Illinois Department of Registration and Education no longer requires that a physician acquire approved CME credits for renewal of the physician's license. Prior to January, 1984, the Department required 100 credit hours of approved CME during the two year term of the license.

The Joint Commission on Accreditation of Hospitals (hereafter "JCAH") requires that, "All individuals with delineated clinical privileges participate in continuing education." The required characteristics of Standard VII of the new (1985) medical staff chapter emphasize the need for the hospital-sponsored program to be related to the types of patient care offered, the results of quality assessment activities and the expressed needs of individuals with clinical privileges. It also states that documentation of a staff member's participation in CME, "is considered at the time of reappointment to the medical staff and/or renewal or revision of individual clinical privileges." *JCAH Accreditation Manual for Hospitals,* 1985.

Darling v. Charleston Hospital, 33 Ill. 2d 326 (1965), established the principle that hospitals may be liable for failing to supervise the quality of care provided by a physician. The court also allowed JCAH standards to be admitted as evidence of the appropriate standard of care. Because the JCAH has made CME part of the supervisory responsibility of a hospital, it is important for the medical staff to create a

meaningful hospital-sponsored CME program. The credentialing process is an important part of the supervisory role of the hospital, and therefore it is appropriate for the credentials committee to examine the CME achievements of medical staff members during the reappointment process.

V. Information Used in Peer Review and Quality Assurance: Confidentiality and the Qualified Privilege

The peer review which is part of the appointment/reappointment process and the quality assurance program of a hospital is only effective if medical staff members are willing to provide frank and candid evaluations of any deficiencies in the quality of care provided by a physician whose credentials are being examined. To encourage staff members to freely provide information to committees which are reviewing the credentials of a physician, the Illinois legislature passed the Medical Studies Act, Illinois Revised Statutes, Chapter 110, Section 8-2101 *et. seq.* The Act provides that:

> Sec. 8-2. All information, interviews, reports, statements, memoranda or other data of . . . committees of accredited hospitals, or their medical staffs, including Patient Care Audit Committees, Medical Care Evaluation Committees, Utilization Review Committees, Credential Committees, Executive Committees (but not the medical records pertaining to the patient), used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care, shall be privileged, strictly confidential and shall be used only for medical research, the evaluation and improvement of quality care, or granting, limiting or revoking staff privileges, except that in any hospital proceeding to decide upon a physician's staff privileges, or in any judicial review thereof, the claim of confidentiality shall not be invoked to deny such physician access to or use of data upon which such a decision was based.
>
> Sec. 102. Such information, records, reports, statements, notes, memoranda, or other data, shall not be admissable as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency or person.

The Act has undergone several revisions in response to recent restrictive judicial interpretations of its provisions. For example, in *Matviuw v. Johnson,* 80 Ill. App. 3d 481 (1979), it was held that the former statute's staff privileges exception did not foreclose discovery of information in a defamation action where the plaintiff, Dr. Matviuw, alleged that false statements made by the defendent physician to the hospital executive committee caused the loss of Matviuw's staff privileges. The court in *Matviuw* further held that the Act only afforded a qualified privilege which did not protect false statements made out of ill will or malice.

The current Act limits the staff privilege exception to hospital proceedings involving determinations regarding staff privileges and judicial review of such proceedings and also explicitly characterizes the protection afforded by the Act as privileged rather than merely confidential. Although the court refused to apply the amendments retroactively to *Matviuw,* in a subsequent opinion (*Matviuw v. Johnson,* 111 Ill. App. 3d 629 (1982)), it agreed that the amended version of the statute would render such information privileged in future cases.

The Act also now provides that materials covered by its provisions are non-discoverable. This amendatory language legislatively overruled *Walker v. Alton Memorial Hospital Assn.* 91 Ill. App. 3d 310 (1980), a malpractice case, in which it was held that a hospital committee's reports regarding the alleged incident were discoverable under the former Act and subject to the trial court's inspection for a determination as to their admissability into evidence. *Walker* itself had been restricted by *Mennes v. South Chicago Community Hospital,* 100 Ill. App. 3d 1029 (1981), a wrongful death action, in which it was held that information regarding staff privileges, as opposed to information regarding the particular patient's care such as requested in *Walker,* was not discoverable.

A recent Illinois Supreme Court ruling has upheld the validity of the Act's protection of the peer review process and its exception for physicians. The court overturned a decision by a circuit court judge, who held that the privilege and confidentiality granted by the Act was unconstitutional and could not be invoked to deny a medical malpractice plaintiff access to peer review records. (*Jenkins v. Wu,* Circuit Court of Cook County, County Dept., Law Division, No. 80 L 6516)

Following a review of the Act's legislative history, the Supreme Court stated:

> . . . It is apparent that the Act represents an attempt by the Illinois legislature to promote quality health care by encouraging physicians to police themselves. This purpose would definitely be thwarted if, as the plaintiff contends, these reports were discoverable in medical malpractice cases. Conversely, the narrow exception provided for physicians is necessary and does not undermine the Act's stated purposes. [*Jenkins v. Wu,* Docket No. 58791, (May 25, 1984) Slip. Op. at p. 8]

In *Memorial Hospital for McHenry County v. Shadur,* 664 F. 2d 1058 (7th Cir. 1981), a federal court of appeals held that the statutory privilege granted by the Medical Studies Act to records of peer review and quality assurance activities would *not* be recognized by a federal court in an anti-trust action brought by a physician against a hospital.

The case involved a physician who charged that staff members of a hospital used the committee process to exclude the plaintiff from the medical staff, thereby effectively destroying his practice. The plaintiff requested production of all documents relating to proceedings instituted by the hospital against physicians who had applied for or were granted admission to its medical staff. The court acknowledged that the records of such proceedings are privileged under the Medical Studies Act. However, it held that the federal interest in preventing antitrust violations was greater than the state's interest in an effective peer review and quality assurance system, and the court granted the plaintiff's discovery request. Ch. 111. S. 4406, of the Illinois Revised Statutes states:

> While serving upon any . . . committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital . . . or improving or benefiting of patient care and treatment whether within a hospital or not, or for the purpose of professional discipline, any person serving on such a committee, and any person providing service to such committee shall not be liable for civil damages as a result of his acts,

omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct.

The above statute was held to defeat a physician's action against members of a hospital surgery committee based on their evaluation and denial of the physician's application for a consultant position in *Settler v. Hopedale Medical Foundation,* 80 Ill. App. 3d 1074 (1980). The court refused to entertain the assertion that the statute was unconstitutional special legislation as the plaintiff was not in the class of persons eligible to raise the issue.

There are several steps which a medical staff can take to avoid unfounded defamation actions against persons who serve on or provide information to committees which examine the credentials of applicants and staff members:

(1) The medical staff bylaws can provide that all persons seeking appointment or reappointment must consent to a thorough investigation of their qualifications. All information to be gathered is to be strictly confidential, and be made available to the subject of the investigation only to rebut charges in hospital committee proceedings and any judicial review thereof;
(2) The bylaws can further provide that all applicants and all staff members must agree to waive any cause of action against all persons providing information to the appropriate committees provided that those persons act in good faith; or
(3) There can be a requirement that the applicants and members must waive any cause of action against any person serving on a committee which reviews the credentials of staff members and applicants, provided those committee members do not engage in willful and wanton misconduct.

The inclusion of such bylaws provisions puts everyone on notice about the rights of the parties involved in the credentialing process. It also facilitates proving to a court that a physician consented to the standards set out in the bylaws.

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7. *Garrow v. Elizabeth General Hospital and Dispensary,* 79 N.J. 549, 401 A. 2d 533 (1979)
8. Illinois Institute for Continuing Legal Education, *Representing Health Care Institutions,* section 18.9
9. *Pollock v. Methodist Hospital,* 392 F. Supp. 393 (1975), upholding a requirement of $1 million coverage; *Renforth v. Fayette Memorial Hospital,* 383 N.E. 2d 368 (Ind. App. 1978), *cert. denied,* 100 S. Ct.273 (1979), upholding a requirement of $100,000 coverage; *Holmes v. Hoemako Hospital,* 573 P. 2d 477 (Ariz. 1977), upholding a requirement of $250,000 coverage.



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Together We Can Make a Difference

The Legislative Internship

Something new was added to the Springfield scene during the spring of 1984. From April through June, while the legislature was in session, twenty-two physicians' wives were seen around the Capitol. It was a first for the physician's wife to be part of the "Doctor of the Week" program.

Two to six ladies arrived early each Tuesday morning for an orientation including: (1) a comprehensive course in how to find offices, people, hearing rooms, etc., in the state Capitol and environs; (2) committee hearings they should attend; (3) representatives and senators they should visit and (4) House and Senate sessions to attend.

Next the ladies received a thorough briefing on the legislative issues:

1. S.B. 450-Optometric Drug Bill
2. H.B. 713-Pre-judgement interest
3. S.B. 495-Cost Containment Bill.
4. S.B. 1768 H.B. 2975-Comprehensive Act; limits recovery for non-economic losses.
5. S.B. 1769 & H.B. 2976-Limits recovery for non-economic losses to $100,000.
6. S.B. 1770 & H.B. 2977-Amends Wrongful Death Act.
7. S.B. 1771 & H.B. 2978-Requires juries to itemize verdicts.
8. S.B. 1772 & H.B. 2979-Establishes pre-trial screening panels.
9. S.B. 1773 & H.B. 2980-Eases the burden of proof necessary to sustain counteractions for malicious prosecution.
10. S.B. 1774 & H.B. 2981-Provides that an attorney may be liable for expenses incurred by the other party.
11. S.B. 1775 & H.B. 2982-Reduces damage awards by the total amount of funds received from other sources.
12. S.B. 1776 & H.B. 2983-Requires expert witnesses to be licensed in Illinois and requires that such witnesses devote at least 75% of their time in active clinical practice in the specialty of the defendant.
13. S.B. 1777 & H.B. 2984-Limits contingency fees of attorneys representing plaintiffs in medical malpractice cases.
14. S.B. 1778 & H.B. 2985-Permits a party named in a suit to file an affidavit disclaiming involvement rather than answering the suit.

The ladies learned the reasons for supporting these pieces of legislation. They learned the cost of professional liability insurance; how the sizes of damage awards and claims settlements have continued to rise; the high cost of frivolous suits and the cost of practicing defensive medicine.

Tuesday evening and Wednesday evening they were expected to take their representative and their senator to dinner. In some instances, breakfast or lunch was the setting for more intense discussion of the issues facing medicine.

This was an action packed, fast-paced, two and one-half days in Springfield for the physician's wife. The program was designed to familiarize the Auxiliary members with the operation of the Illinois state legislature and public issues of importance to medicine. They learned to communicate with their legislators and were able to carry an important message home: "Together We Can Make a Difference." They came away from Springfield with great enthusiasm, a feeling of being better informed, and a well earned sense of having given support to their physician husbands. All asked that we continue the program during the next session of the Legislature.

These auxilians are now considered to be key-contact people, and will be available when the Society needs them in Springfield.

A special 'thank you' must be given to the Illinois State Medical Society for their generous support of this program; and another 'thank you' to our special Governmental Affairs Staff, Jeff Holden and Jim Tierney, for their patience, understanding, and thoughtfulness during a very busy time. ◀

Pam Taylor
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(Continued from page 9)

DIAGNOSIS: ROUND ATELECTASIS

Although a fungus ball may appear as a peripheral density on a chest radiograph, it is usually due to Aspergillus growing in a pre-existing cavity, most commonly in the upper lobes. A fungus ball can be excluded because there is no evidence of a cavity. A loculated empyema may appear as a pleural based mass but it would not be expected in a healthy, asymptomatic patient. A mesothelioma would be an important possibility if there were radiographic changes due to asbestos exposure, and these neoplasms do occur in patients without evidence of such exposure. A bronchogenic carcinoma is the principle consideration in this patient, especially with the long smoking history. Mesothelioma and bronchogenic carcinoma however, do not explain the presence of the curvilinear density extending toward the hilum in this patient. The combination of a peripheral pleural based mass, extensive pleural thickening and this characteristic curvilinear density extending toward the hilum lead to the diagnosis of round atelectasis.

Despite these findings, the patient underwent thoracotomy. At surgery, a portion of the lower lobe and lingula were collapsed and entrapped by a thickened visceral pleura. After decortication the lung totally re-expanded with no evidence of a mass.

The detection of a solitary pulmonary mass on radiographs begins a careful process aimed at excluding malignant neoplasia. If the mass has not been stable in size for one to two years and is not calcified, most patients will undergo biopsy of the mass or thoracotomy. A little-known form of atelectasis called round atelectasis presents as a lung mass which may be mistaken for a neoplasm if its characteristic radiographic features are not recognized.

Round atelectasis is an unusual form of atelectasis that is always associated with pleural disease. It has only recently been described in the American literature[1,2] but has been thoroughly discussed by German investigators.[3,4] Round atelectasis has been variously called folded lung,[5] helical atelectasis,[6] atelectatic pseudotumor,[4] or pleuroma.[7] It presents as a rounded, pleural-based mass, most commonly at the base of the lung posteriorly. Round atelectasis must be differentiated from other pathologic processes that present as mass lesions. Fortunately there are certain characteristic features of round atelectasis. A knowledge of these features is important to prevent invasive diagnostic procedures and unnecessary thoracotomy.

Pathogenesis

The formation of round atelectasis is thought to be initiated following pleural effusion.[1] The cause of the effusion can be varied, although a high fibrin content is probably conducive to the formation of this type of atelectasis. As an effusion forms, the pleural surfaces separate and the finger-like projection of lung that normally resides in the posterior costophrenic sulcus floats on the effusion. A groove or cleft may form on this projection of lung allowing it to fold and rotate posteriorly. As it rotates, the bronchi become kinked, causing complete atelectasis of the projection, which assumes a flattened shape. After this flattened projection of atelectatic lung rotates, it lies adjacent to the uneffected lower lobe tissue. The visceral pleural surfaces are then opposed. If the fibrin content of the effusion is high, a fibrinous deposit forms in the cleft between these two surfaces. Over a period of time, adhesions form and the visceral pleural surfaces become fixed to one another.

The next step in the development of round atelectasis is the regression of the pleural effusion. As the effusion resolves, the adjacent lung reexpands to fill the thoracic cavity. The lung then engulfs the fixed area of atelectasis. As the effusion resolves even further, the atelectatic mass tilts as the rest of the lung surrounds it. This tilting gives the characteristic appearance of the vessels and bronchi curving into the lesion. Round atelectasis also occurs at pleural surfaces above the lung base when effusion compresses the adjacent lung.

The round atelectasis usually does not change its appearance with time.[1] Occasionally, it will move away from the chest wall but retain its size and shape. If the adhesions were not well formed initially they may gradually separate due to the effects of respiration. As these adhesions disintegrate, the atelectasis slowly uncoils and is seen to move down along the chest wall as it becomes smaller. The bronchi slowly open and the mass reexpands. This may continue, on rare occasions, until the mass completely disappears.[3]

Clinical Findings

At the time of the initial diagnosis of round atelectasis, the patient may be asymptomatic. Many lesions have been detected in patients when there was no suspicion of active pulmonary disease. If symptoms are present, they are usually related to underlying pleural disease. Rarely, secondary bronchiectasis develops and produces symptoms. Chest pain may be attributed to an ongoing pleuritis. Cough and dyspnea can be related to residual pleural effusion. Sputum production can be related to the secondary bronchiectasis. Physical examination and clinical signs also correlate with the underlying pleural condition.

Attempts to determine the cause of pleural disease are seldom successful, but an association with asbestos exposure is frequently reported.[8,9] Biopsy of the pleura usually reveals nonspecific inflammation with fibrosis.[2] Patients may, however, give a history of myocardial infarction, congestive heart failure, tuberculous pleural effusion or therapeutic pneumothorax for pul-

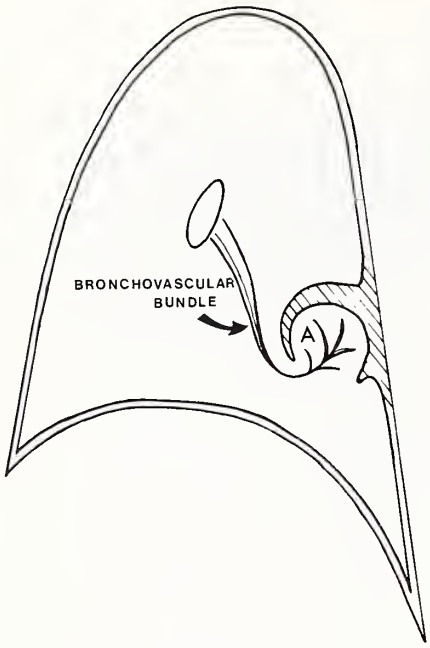


Figure 2.
Diagrammatic representation of round atelectasis. This is a lateral view of the chest. The bronchovascular bundle extends from the hilus and curves into the round atelectasis (A). Diagonal lines indicate thickened pleura.

monary tuberculosis. In many reported cases no symptoms of pleural or pulmonary disease preceded the diagnosis of round atelectasis.

Treatment is seldom necessary. Decortication with the uncoiling of the round atelectasis may be required because of the loss of ventilating pulmonary tissue. This is most often due to an unusually large mass or the development of bronchiectasis. Round atelectasis has been reported to recur after surgical resection.[2]

Radiographic Findings

Radiographically, round atelectasis presents as a rounded, oval or lobulated mass that is usually 2.5-5cm. in diameter.[2] The perimeter may be sharply or poorly defined, but a segment of the border is always blurred or ill-defined due to the entering vessels and bronchi. It is not primarily a segmental disease but the most common location is in the posteromedial or posterolateral aspect of the lower lobe. Less often, the mass has been reported in other locations including the middle lobe and lingula.[3] Simultaneous lesions have also been reported.[4]

The most important finding appears in the surrounding lung tissue. The blood vessels and bronchi are gathered together as they converge toward the mass. This broncho-vascular bundle first courses toward the base of the lung, then arches toward the mass to enter the lower pole of the lesion (Figure 2). This arrangement has been called the "comet" sign and is the most important radiographic finding of round atelectasis.[2] This sign may not be seen in all projections and may be best demonstrated on lateral tomography of the chest. The "comet" sign is usually not well seen in the axial plane on C.T. examinations because the comet tail is oriented vertically as it comes toward the hilum.

Chronic pleural thickening is also essential to the diagnosis. The pleural disease is usually pronounced and most prominent near the mass (Figure 3). There may be blunting of the costophrenic angle and pleural calcification. Pleural fluid is seldom present when the mass is detected but there may be small loculations indistinguishable from thickening. The mass is always connected to a localized segment of especially thickened pleura in at least one projection.

The effected lobe is diminished in volume and a thickened interlobar fissure may be retracted toward the mass. Other signs of lung collapse may be present but they are usually minimal. The ipsilateral hilum may be depressed, the diaphragm may be elevated and the neighboring lung may be hyperlucent due to overexpansion of uninvolved tissue.

If the lesion is followed over a period of time it usually remains static in size and position. There have been reports of the mass decending in the thorax or shrinking and disappearing as the mass uncoiled spontaneously.

Conclusion

Once the characteristic features are recognized, the diagnosis of round atelectasis can be made with confidence. The combination of a pleural based mass, pleural thickening contiguous with the mass, and the "comet" sign is necessary for diagnosis. The diagnosis cannot be made in the absence of these signs. The differential diagnosis of a pleural or pleural based mass includes empyema, loculated pleural effusion, mesothelioma, metastatic tumor and abscess. Although the pleural changes in these conditions may be similar to round atelectasis, the "comet tail" is absent.

An arteriovenous malformation, bronchogenic cyst or peripheral malignant tumor with infiltration toward the hilum may appear as a mass with a tail, but the tail does not take the characteristic sweeping course toward the hilum and the pleural changes are absent.

The diagnosis of round atelectasis should be considered with any pleural-based mass of the lung, especially with a history of asbestos exposure. When plain radiographs or tomography reveal the typical features of this lesion, further invasive procedures can be avoided.



Figure 3.
C.T. scan of the chest. Note the pleural based nature of the atelectatic mass (A) and a portion of the bronchovascular bundle (arrows) as it enters the mass. Although the window is set to demonstrate the lung parenchyma, note that the pleural thickening is much greater on the left. These findings are often better demonstrated by conventional tomography in the longitudinal plane.

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EKG

(Continued from page 18)

Answers: 1. C. D. 2. A. B.

The twelve lead ECG shows a well functioning demand pacemaker across the first three-fourths of the tracing. Only in leads $V_4V_5V_6$ are seen the patient's intrinsic QRS complexes. The pacemaker spike can be best seen in leads I and AVL. Atrial flutter waves are seen in lead V_1. This is AV block present despite the atrial flutter for the first three-fourths of the tracing. The atrial flutter is conducted with a variable AV block in leads $V_4V_5V_6$. There is no ECG evidence of an acute myocardial infarction. In fact, the pacemaker beats camouflage all the evidence for the myocardial infarction that occurred one year ago. The patient has developed congestive heart failure and serial serum enzymes and ECG's ruled out a silent myocardial infarction. Measures to treat the congestive heart failure were appropriate. The patient had taken digoxin for a year and serum digoxin levels were adequate. The pacemaker was functioning well and required no revision. Diuretic therapy was increased. The patient's rales and her dyspnea disappeared. Although she felt comfortable with the increase in diuretic dosage, the cardiomegaly present on the chest X-ray was unchanged from last year. ◀

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Computed tomographic patterns of muscle tissue were evaluated in 35 patients with neuromuscular disease. Neurologic diseases showed muscle atrophy with late onset of reduced muscle density. Primary muscle diseases showed an early onset of decreased muscle density with late onset of muscle atrophy. The computed tomographic appearances may be valuable in the early differentiation of neuromuscular diseases, whether of neurologic or primary muscle involvement and in the assessment of which muscles to biopsy. (Hawley, R., *et al.: Arch Neurol* 41,383-7, 1984)

Atherogenesis was studied in the human aorta in 30 patients who expired secondary to traumatic injuries without prior symptoms of serious illness. The preliminary findings suggest that intimal elastic fibers proliferate into the developing atheromatous plaques. These elastic fibers then lose their DNA, degenerate and may contribute to the total lipid composition of the atheroma. The intimal elastic layer becomes prominent after the second decade of life, becomes focally thickened during the third decade of life and is associated with an increase in amino acids and a subsequent inclusion of lipids. (Greenberg, S., *et al.: Proc Inst Med Chgo* 37:1, 1-4, 1984)

Forty-three patients with acute myocardial infarction within four hours of onset had total occlusion confirmed by angiography. Reperfusion was achieved in 69% of patients with use of intracoronary streptokinase, and in 17% of cases treated by intracoronary nitroglycerin. Comparison of radionuclide ejection fractions 10-14 days after infarction failed to show improvement in either of these two treatment methods. Patients with subtotal occlusion on baseline angiography demonstrated a significant spontaneous improvement in their ejection fractions over a two week period. (Leiboff, R.H., *et al: Am J Cardiol* 53:404-7, 1984)

Oral contraceptives and estrogens given for menopausal and post-menopausal symptoms did not offer any protection against the development of rheumatoid arthritis in 229 women with rheumatoid arthritis and in 458 control patients. This study conflicts with findings reported in Great Britain and the Netherlands. (Linos, A., *et al: Lancet* 1:1299-1300, 1983)

Changes in the distal interphalangeal joints have previously been considered characteristic of only osteoarthritis and Heberden's arthritis. Clinical comparisons revealed distal interphalangeal joint changes in 67 of 100 patients with rheumatoid arthritis and in 33 cases of 40 patients with generalized osteoarthritis. Radiologic findings of soft tissue swelling, subchondral cysts, osteophytes, ossicles and narrowing of joint space can occur in both groups. (Campion G.: *Br Med J* 287:1512, 1983)

Two groups of matched patients, 150 with acute myocardial infarction and 150 control patients were evaluated for the incidence of acute respiratory symptoms. A total of 42 patients with acute myocardial infarct had had an upper respiratory infection while only 23 in the control group had an upper respiratory infection. The authors suggest that a viral infection of the upper respiratory tract may be a pathogenetic factor in the onset of myocardial infarction. (Spodick, D., *et al.: Am J Cardiol* 53:481-2, 1984)

The effect of zinc supplements in treatment of the common cold was evaluated in a double-blind, placebo-controlled clinical trial. Zinc gluconate lozenges or a matched placebo were given to patients every two hours while awake. After seven days, 86% of the zinc treated patients were symptom free contrasted to only 46% of the placebo treated patients. Zinc lozenges shortened the average duration of the common cold by about seven days. (Eby, G., *et al:* "Antimicrobial Agents," *Chemother.*, 25:20-4, 1984)

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510 Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

AUGUST

Surgery

Soft Tissue Surgery Workshop
For: MDs. Workshop, August 4-5, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St., Louis 63110. **Fee:** $290. **Reg. Limit:** 60. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Specialty Review in General Surgery, Part II
For: Surgeons. Lecture, August 20-31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Reg. Limit:** TBA. **Credit:** Category 1, 100 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Fiberoptic Colonoscopy
For: MDs. Lecture, August 22-24, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Fiberoptic Esophagogastric Endoscopy
For: MDs. Lecture, August 27-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Sports Medicine

Seventh Annual Sports Medicine Symposium
For: MDs, Sports Professionals. Symposium, Workshop, August 3-4, Waunakee, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AOA, TBA; UW-Extension CEU's, TBA. Contact: Sarah Aslakson. Phone: 608-263-2856

Urology, Radiology

Endourology and Ureteroscopy: Triumphs and Pitfalls
For: Urologists, Radiologists. Lecture, August 3-4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 90. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Radiology

Sixth Annual Cape Cod Summer Symposium on Ultrasound, CT, and MR
For: Radiologists, Technicians. Symposium, August 6-8, Hyannis, Massachusetts. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $250 MDs; $175 Res., Tech. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; UW-Extension CEU's, 13. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Internal Medicine

Specialty Review in Internal Medicine/Certifying
For: MDs. Lecture, August 5-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** TBA. **Credit:** Category 1, 72 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Clinical Medicine

National Symposium on Sexually Transmitted Disease
For: MDs. Symposium, August 10-12, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** Skokie Valley Hospital/Foundation, Program Office, 9600 Gross Point Rd., Skokie 60076. **Fee:** $295. **Reg. Limit:** 400. **Credit:** Category 1, 15 hours; AAFP Prescribed, 15 hours. **Contact:** Craig Olesen. **Phone:** 312-677-9600, Ext. 3354

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, August 28, 4:30-6:30pm, North Chicago. Sponsor: University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

SEPTEMBER

Internal Medicine

Gastrointestinal Disorders
For: MDs, Office Staff. Symposium, September 6, 2:30pm, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Specialty Review in Hematology
For: Hematologists, Oncologists, Internists. Lecture, September 30-October 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $550. **Reg. Limit:** TBA. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Specialty Review in Nephrology
For: Nephrologists, Internists. Lecture, September 30-October 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Weight Control

Weight Control Workshop
For: MDs, RNs, Allied Health Professionals. Workshop, September 10-14, La Crosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program Education Services Unit, Room 221, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU's.

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Neurology, Pharmacology, Psychiatry

Headaches: Biological Mechanisms and Clinical Aspects
For: MDs. Lecture, September 12, 8am, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, Departments of Pharmacology, Neurology & Psychiatry, 3333 Green Bay Rd., North Chicago 60064. Fee: $50 MDs; $25 Others. **Reg. Limit:** None. **Credit:** Category 1, 6 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Surgery

Visiting Professor Lecture Series
For: MDs. Lecture, September 12, 2pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, Department of Surgery, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Specialty Review in General Surgery—Part I
For: Surgeons. Lecture, September 17-28, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $750. **Reg. Limit:** TBA. **Credit:** Category 1, 98 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

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Fiberoptic Colonoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, September 19-21, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $490. **Reg. Limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, September 24-26, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $490. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Dermatology
Specialty Review in Dermatology
For: Dermatologists. Lecture, September 17-21, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $490. **Reg. Limit:** 90. **Credit:** Category 1, 34 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Nuclear Cardiology
Ninth Annual Nuclear Cardiology Symposium
For: Cardiologists, Radiologists. Symposium, September 19-22, Milwaukee, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; UW-Extension CEU's, Voice Credit. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Medical Practice
Second Annual Conference on Current Medical Events
For: MDs. Symposium, September 20-21, Springfield **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Infection Control
Advances in the Control of Nosocomial Infection—1984
For: MDs, RNs, Allied Health Professionals. Conference, September 20-21, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Use of New Antibiotics
For: MDs, Office Staff. Symposium, September 22, 1pm, Mt. Carmel, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Pediatrics
For: Pediatricians. Lecture, September 24-26, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $410. **Reg. Limit:** 90. **Credit:** Category 1, 24 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Medicine and Pathology
Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, September 24, 4:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, Departments of Medicine & Pathology, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

OCTOBER

Critical Care Medicine
Third Annual Critical Care Symposium
For: MDs. Lecture, October 11-14, 8am, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** University of Health Sciences/The Chicago Medical School, Department of Medicine, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $360/MDs, $240/Others. **Reg. Limit:** None. **Credit:** Category 1, 24.5 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Endocrinology and Metabolism
Recent Advances in the Diagnosis and Management of Endocrine Related Disorders
For: MDs. Seminar, October 11-12, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $200. **Reg. Limit:** TBA. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours; AOA, 14 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Pediatrics
New Perspectives in Pediatric Hematology/Oncology—Focus on the Practice Aspects of Diagnosis and Management
For: Pediatricians. Course, October 12-13, Chicago. **Sponsor:** The University of Illinois College of Medicine at Chicago, Department of Pediatrics, 912 S. Wood Street, Chicago 60612. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, 14 hours. **Contact:** Conferences and Institutes. **Phone:** 312-996-8025

Seminars in Pediatrics
For: Pediatricians and GPs. Seminar, October 12-13, Madison, WI. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $100. **Reg. Limit:** None. **Credit:** Category 1, 10 hours; AAFP, TBA; AOA, TBA; UW-Extension CEU's, 10. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Cardiovascular
Second Annual L. R. Nelson Cardiovascular Conference
For: MDs, CV Nurses and Technicians. Conference, October 13, Peoria. **Sponsor:** Methodist Medical Center of Illinois and the Methodist Medical Center Foundation, 221 N.E. Glen Oak, Peoria 61636. **Fee:** $15. **Reg. Limit:** 125. **Credit:** Category 1, 5 hours. **Contact:** Irving Favus, M.D. **Phone:** 309-672-5737

Surgery and Otolaryngology
Advances in Scar Revision and Camouflage
For: MDs. Seminar, October 15-17, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $350-$375. **Reg. Limit:** TBA. **Credit:** Category 1, 21.25 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Gynecology
Colposcopy and Clinical Management of Cervical Cancer
For: MDs. Lecture, October 26, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $100/MDs; $40/Others. **Reg. Limit:** None. **Credit:** Category 1, 8 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Medicine and Pathology
Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, October 29, 4:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago IL 60603.

BLOOMINGTON:
Internal Medicine—to join an active six member group of general internists in Bloomington—Normal, Illinois. Subspecialty in rheumatology or pulmonary medicine desirable, but not necessary. Contact: Judy Buchanan, administrative director, The Health Center, 702 N.E. Street, Bloomington, Ill. 61701. (309) 827-5051. (8)

GIBSON CITY:
Internist/Cardiologist—Excellent opportunity in East Central Illinois; modern, well equipped hospital, sophisticated ICU, attached private SNF: new professional office space and incentives available; rural community within 30 minutes of major university, tertiary care center, metropolitan area with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City 60936. 217-784-4251. (8)

GLEN ELLYN:
Expanding multi-specialty group in far western suburbs of Chicago seeks 2 internists. One position involves general internal medicine practice; the other will be essentially a five day per week institutionally based practice with little night or weekend responsibility. Area has excellent schools, housing and recreational facilities. Write: Dave Bauer, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Avenue, Glen Ellyn, Ill. 60137 (312) 469-9200. (8)

KEWANEE:
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LA CROSSE, WI—Orthopedic Surgeon/Otolaryngologist needed to join 50-physician multispecialty group in city of 50,000 in beautiful Mississippi River Valley with patient drawing area of 175,000. Very busy two-physician Orthopedic Department. One young, board-certified otolaryngologist (only ENT specialist on hospital staff). Modern 350-bed, full-service hospital (adjacent to clinic) has well-equipped and staffed OR, comprehensive radiology (including CT scan/ultrasound), 24-hour E.R. staffing. Attractive compensation package (first year guarantee plus incentive) and generous fringe benefits. Contact P.S. Shultz, M.D., Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S. 10th St., La Crosse, WI 54601. Phone 608/782-9760.

GASTROENTEROLOGIST—NEUROLOGIST—NEUROSURGEON Independent group of private practitioners searching for an independent-practice oriented BC/BE gastroenterologist, neurologist, and neurosurgeon. Referral base includes 100 physicians, serving a population of 120,000. Unlimited recreational activities, medium sized university city. Immediate need. Chippewa Valley Independent Physicians, P.O. Box 1725, Eau Claire, Wisconsin 54701.

SOUTHERN CALIFORNIA family medical practice fror sale. Idyllic location near ocean in beautiful Santa Barbara. Gross $150,000. Physician owner must leave country for family reasons. Call 805-967-9668.

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OPERATING CORPORATION of several medical centers providing primary care for senior citizens, seek board certified or board eligible, Florida licensed M.D.s with the following specialties . . . family practice, internist, cardiologist and radiologist. Salary plus incentive. Insurances paid. Association fees paid. Contact Mr. Ed Hoke, H.S.C. Medical Centers, 1529 U.S. 19 South, Levitz Center, Clearwater, Fl. 33546. Phone 813/530-9455.

PHYSICIAN OPPORTUNITIES: Current openings for family practitioners, internists, general surgeons, industrial physician. Chicago suburb, south. Reply to Box #1122, c/o the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago IL 60603.

EMERGENCY DEPARTMENT ASSOCIATE DIRECTOR—Illinois progressive facility with strong community orientation in Western Illinois seeks board certified/eligible FP, IM,

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MEDICAL ONCOLOGIST—An ideally located, progressive and family-oriented community offers an excellent professional and living environment for a board-qualified or board-certified oncologist. Serving this northwest Illinois community is a JCAH approved 250 bed acute care modern hospital with a service area of 54,000. The community offers good primary and secondary schools and a highly rated junior college and is situated near plentiful recreational facilities. Please respond to: Stephen A. Menke, Vice President, Freeport Memorial Hospital, 1045 W. Stephenson, Freeport, IL 61032.

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MISSOURI AND ILLINOIS—Emergency Medicine. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Amy Eisenman, Staffing Specialist. National Emergency Services, Inc, 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

MEDICAL DIRECTOR. Opportunity for physician with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; phone 608-251-4156.

FAMILY PRACTICE. Rapidly expanding staff model HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; 608-251-4156.

OB/GYN. Group Health Cooperative has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; phone 608-251-4156.

INTERNIST: 12 physician multi-specialty group near Peoria seeking second internist for primary care, consult, and ICU management responsibility. Some non-invasive cardiology skills beneficial. Modern clinic, 225-bed hospital with trauma center. Negotiable first year salary, productivity, extensive benefits. City of 16,000 with good schools and recreation. Phillip Kelbe, Fox Hill Associates, 260 Regency Court, Waukesha, WI 53186, (414)785-6500.

CARDIOLOGIST: Partnership available in Waukegan (65,000) on Lake Michigan between Chicago and Milwaukee. Affiliated with two major hospitals, excellent clinical facilities. Noninvasive emphasis. Excellent salary, complete benefits. Senior partner retiring. Phillip Kelbe, Fox Hill Associates, 260 Regency Court, Waukesha, WI 53186 (414) 785-6500.

OBSTETRICIAN-GYNECOLOGIST needed for prosperous community of 12,000 which is 1½ hours from the Chicago Loop in central Illinois. Minimum guarantee $150,000. Please submit CV to Bromley and Associates, 1010 Jorie Blvd., Suite 234, Oak Brook, IL 60521, or phone 312-986-5870.

FAMILY PRACTITIONER—Exceptional opportunity in an already proven practice. Over 2,000 medical records in the doctor's current practice. Very adequate office facilities with attached living space available. Physician must be willing to do total family practice including obstetrics and be a medical staff member of a 105-bed acute care hospital located approximately 15 miles away. Physician previously occupying this practice has recently had a CVA and is unable to return to practice. Contact H. Herman, Executive Vice President, St. Clement Hospital, Red Bud, IL 62278; (618) 282-3831.

FEMALE OPHTHALMOLOGIST seeking part-time Locum Tenens—fall 1984. Northeast Illinois. Senior resident considered. Call after 7 p.m. 312-234-4305, Dr. Litvin.

FAMILY PRACTITIONER—MD/DO to join young physician in town of 5,000. 80 miles south of Chicago. New clinic, 250-bed hospital. Guaranteed salary. Contact: Raymond Wolf, call collect 414/785-6500.

PEDIATRICIAN (BC/BE) to join growing primary/referral practice. Level II nursery. Suburb of Milwaukee, Wisconsin. First year income guarantee. Contact Raymond Wolf, 250 Regency Court, Waukesha, WI 53186.

MEDICAL DIRECTOR Established Staff Model HMO with multiple locations, servicing in excess of 30,000 members seeking a full-time Medical Director. Must be board certified with strong managerial skills, commitment to quality care and ability to work with strong management team. Prior HMO experience helpful but not necessary. Salary open with excellent benefit package. Reply to Box #1126, the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

OBSTETRICIAN/GYNECOLOGIST—Board Certified or Eligible, July 1984 or earlier, to join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, IL 61032.

PHYSICIANS NEEDED for part-time work under contract to the Social Security Administration's Disability Programs Branch in downtown Chicago. Experience in review of medical evidence in disability claims and board eligibility preferred. No contact with patients. Unrestricted license in any state required. Interested parties should submit Curriculum Vitae by August 3, 1984 to: Social Security Administration, DPB/MCS 32nd Floor, 300 South Wacker Drive, Chicago, Illinois 60606.

URGENT CARE CENTER—Position available for physician trained/experienced in primary care (family practice, internal medicine, emergency medicine) in center in eastern Iowa (approx. 400,000 pop.). Emphasis on quality of care with opportunity for personal and financial growth. Contact J. Koehler, M.D., East Kimberly Urgent Care Center, 2120 East Kimberly Road, Davenport, IA 52807, (319) 359-1301.

FAMILY PRACTITIONER—Excellent opportunity to work in established clinic. Rural community located close to metropolitan city. Family oriented community. Send CV to Chief Executive Officer at Iroquois Memorial Hospital, 200 Fairman Street, Watseka, Illinois 60970.

ORTHOPEDIC SURGEON—Excellent opportunity for practice development in Midwest hospital of 160 beds. Significant growth potential in an economically sound area. Attractive compensation package available. Send CV to Chief Executive Officer at Iroquois Memorial Hospital, 200 Fairman Street, Watseka, Illinois 60970.

WEST SUBURBAN PEDIATRIC PRACTICE For sale. Well-established practice with net income in the high 90's; Dr. will remain to effect a smooth transition. Send inquiries to: MBC Practice Sales, P.O. Box 722, Park Ridge, Illinois 60068.

BOARD CERTIFIED, 35-ish, male family physician with rapidly growing practice in Baltimore-Washington area seeks associate interested in and familiar with women's medical needs. POB 684 Columbia, MD 21045.

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Horton, 179 W. Washington, Suite 1100, Chicago, IL 60602, or call (312) 372-1539.

CONSULTANTS NEEDED: orthopedics, neurosurgery, anesthesiology, oncology and pediatric surgery. Fee for service on a spare time basis. Apply to: Health Care Standards, 155 N. Michigan, Suite 751, Chicago, IL 60601.

OBSTETRICIAN—Position available for physician for patient care in obstetrics and gynecology. Responsibility to treat patients on individual basis in an office as well as all hospital physician care of patient, education and teaching of OB/GYN techniques, to nursing staff and physician staff, surgery performed in his specialty, deliver babies. Education: MD degree, five years internship/residency, one year practice experience. Usual and customary schedule (40 hours) with gross salary of $80,000 annual. Applicant should send resume to: Illinois Job Service, 705 Kilburn Avenue, Rockford, Illinois 61103. Attn: Andrew I. McAuley, Ref. #202. An Employer Paid Ad.

ELGIN—General Practice for Sale—retiring 80 year old practice—from father to son. Includes medical and office equipment. 1100 Larkin Ave., Elgin, IL 60120; (312) 742 3643.

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SITUATIONS WANTED

POSITION WANTED—RADIOLOGIST seeking position full time, part time or locum tenens. Trained in diagnostic modalities. Write to Box #1096 c/o *Illinois Medical Journal*, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

PHYSICIANS DESIRE RELOCATION. Husband, family practice and general surgery; wife OB/GYN and anesthesiology, desire practice opportunity in community of 5000 with small hospital. Write to Box #1119, c/o *Illinois Medical Journal*, 55 E. Monroe, Suite #3510, Chicago, IL 60603.

A BOARD PREPARED PHYSICIAN in emergency medicine seeks general practice—solo, group, associate or salaried in Illinois. Contact Box No. 1120 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

SITUATION WANTED. Experienced internist available for HMO, group or solo primary care practice. Salaried employment desirable. Will also consider to share, rent or purchase. Write to Box #1125, c/o the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603, or call (312) 352-4282.

PEDIATRICIAN, seeking position full-time or part-time to join an obstetrician or a group of physicians. Available July 1, 1984. Write or call: Dr. Sandesara, 5906 North Sheridan Road, #4A, Chicago, Illinois 60660; (312) 769-4384 (after 6:00 p.m.).

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FOR SALE—Doctors practice and full equipped medical office building—80th & Western Ave. Reception and three (3) examining Rooms. Central heating/air conditioning. Excellent transportation. For appointment call—(312) 332-6233.

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MEDICAL BUILDING—For Sale. Located in southwest suburb. Approx. 7,700 sq. ft. Two waiting rooms, 22 examining rooms, X-ray room, lab, parking for 60 cars. Contact: Christine Hauser (312) 368-5832 or Gus Zaharias (312) 368-5836 of Baird & Warner Corporate Group.

EXCELLENT OFFICE/LABORATORY space available, 600 to 1300 sq. ft. for medical or medical-related fields. Deluxe office building in Skokie on prime Skokie Blvd. with extensive parking. Extremely reasonable with immediate occupancy. Call Mabadi Realty, (312) 675-8693; 8694.

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DOWNERS GROVE—Greenbriar Medical Center. Close to Good Samaritan Hospital. Prime first floor office for lease, 700 sq. ft. to 1500 sq. ft. Waiting room, examining rooms, leaded X-ray room plus private offices. Flexible terms, plenty of parking. Immediate occupancy. Call Mr Mittchell (312) 969-8330 or RE/Max Young Kim (312) 964-4000.

MISCELLANEOUS

INTERESTED IN FINDING a certified physician assistant for your busy practice? A free placement service is offered through: Illinois Academy of Physician Assistants, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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On Federation



In an earlier President's Page, I commented that, through our organizational process, matters germane to the practice of medicine can be discussed and acted upon at the appropriate level — city/county, state or national. Certain issues which affect us individually are federal in nature and a national forum is required for their disposition. In June, the annual meeting of the American Medical Association served as that forum. Having participated in that meeting as one of your delegates, I would like to share with you just a few of the many important things that took place.

Since they are a nationwide concern, DRGs were a prominent portion of the agenda. As a result, the AMA will closely assess and evaluate the impact DRGs will have on the cost, availability and quality of medical care and will report to the House of Delegates periodically. The "attestation statement" was universally abhorred, and the House directed that strong and concentrated efforts be made to seek its elimination. A letter from AMA to the Health Care Financing Administration has been written stating that "the attestation requirement remains objectionable and should be deleted."

Sharing our own concern with the special problems of Foreign Medical Graduates, the AMA Board and Trustees established an Ad Hoc Committee to address their situation. I am very happy to report our own Pedro Poma was named as chairman.

We have finally seen some advantage to being a "unified state" in that we are now entitled to two more delegates to the AMA. Following discussions with the AMA Board, I feel we will be subject to further concessions.

We are very proud of the fact that Ron Davis became the *first* elected resident member of the AMA Board of Trustees. This came about through the hard work of our delegation and the fact that we had an exceptional candidate.

The emergence of the Hospital Medical Staff Section as a potent force in the AMA is gratifying. Addressing concerns with the Joint Committee on Accreditation of Hospitals, including medical staff rights and privileges, several significant actions were taken.

Although it is ultimately a state problem with national involvement, and a federal governmental solution would be inimical, the AMA established a special task force to study malpractice and professional liability. It will coordinate present activities and recommend actions to be taken on a state-to-state basis.

The motto of our state is "State Sovreignty, National Union." I think it applies to our society as well, but, to paraphrase the philosopher: if we did not have an AMA, we would have to create one. ◀

Robert C. Hamilton, M.D.
President

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Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

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Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end-diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Obituaries

Bartelsmeyer, E.C., Taylorville, died June 1, 1984 at the age of 65. Dr. Bartelsmeyer was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

***Baylor, John E.,** Northfield, died June 20, 1984 at the age of 67. Dr. Baylor was a 1943 graduate of Northwestern University Medical School, Chicago.

***Beinoris, Bruno A.,** Wood Dale, died May 18, 1984 at the age of 63. Dr. Beinoris was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

***Freeman, Wendel,** Champaign, died June 14, 1984 at the age of 72. Dr. Freeman was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

***Halley, Henry H.,** Alton, died May 15, 1984 at the age of 73. Dr. Halley was a 1937 graduate of Northwestern University Medical School, Chicago.

****Hoffman, Hans,** Clearwater, Florida, formerly of Cambridge, died April 17, 1984 at the age of 83. Dr. Hoffman was a 1926 graduate of Albertus-Universitat Medizinische Fakultat, Konigsberg, Prussia.

****Hopkins, J. Harold,** Champaign, died May 12, 1984 at the age of 81. Dr. Hopkins was a 1927 graduate of Northwestern University Medical School, Chicago.

***Judson, Glenn L.,** Elmhurst, died July 10, 1984 at the age of 69. Dr. Judson was a 1941 graduate of Northwestern University Medical School, Chicago.

****Ladd, Dwight J.,** DeKalb, died November 4, 1983 at the age of 84. Dr. Ladd was a 1927 graduate of the Harvard Medical School, Boston.

****Lambert, Claude N.,** Chicago, died June 18, 1984 at the age of 81. Dr. Lambert was a 1928 graduate of Rush Medical School, Chicago.

***Luke, George R.,** Ashburn, died November 10, 1983 at the age of 71. Dr. Luke was a 1942 graduate of the University of Health Sciences/Chicago Medical School.

****McCuistion, Hubert P.,** Alton, died January 29, 1984. Dr. McCuistion was a 1925 medical school graduate.

Nisi, Edward A., Westville, Indiana, formerly of Chicago, died June 13, 1984 at the age of 70.

Paiva, Rosalia E.A., Springfield, died June 1, 1984 at the age of 51.

***Parker, George M.,** Peoria, died June 17, 1984 at the age of 74. Dr. Parker was a 1935 graduate of Northwestern University Medical School, Chicago.

****Pollack, Herbert C.,** Chicago, died June 26, 1984 at the age of 84. Dr. Pollack was a 1924 graduate of Schlesische-Friedrich-Wilhelms-Universitat Medizinische Fakultat, Breslau, Prussia.

***Prec, Oldrich,** Downer's Grove, died July 4, 1984 at the age of 75. Dr. Prec was a 1943 graduate of Oxford University Medical School, Oxford, England.

****Ross, Charles A.,** Galesburg, died May 27, 1984 at the age of 77. Dr. Ross was a 1934 graduate of Northwestern University Medical School, Chicago.

Rossell, Charles E., Seattle, Washington, died May 10, 1984 at the age of 66. Dr. Rossell was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

Schultz, Whitt N., Wilmette, died May 28, 1984.

****Tucker, Beatrice,** Chicago, died June 12, 1984, at the age of 86. Dr. Tucker was a 1922 graduate of the Loyola University Stritch School of Medicine, Maywood.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

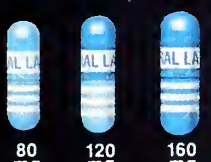
PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) *LONG ACTING CAPSULES*

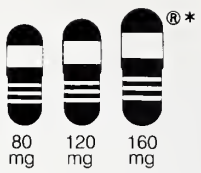


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JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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New York, N.Y. 10017

DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Three ISMS members attained American Medical Association leadership posts during their annual meeting in June. **Joseph H. Skom, M.D.,** Chicago, an ISMS past president, was re-elected to the Council on Scientific Affairs. **Ronald M. Davis, M.D.,** a resident physician, was elected to the newly-created resident position on the AMA Board of Trustees. **Pedro A. Poma, M.D.,** Chicago, a trustee for both ISMS and the Chicago Medical Society and chairman of the ISMS publications committee, was appointed chairman of the new AMA Ad Hoc Committee on Foreign Medical Graduates.

Herb Trace, M.D., Evanston has been named Illinois chairman for the American Medical Society on Alcoholism (AMSA). At a recent meeting, several national groups agreed that AMSA would pursue certification for physicians treating alcoholism and alcoholics. Interested persons may contact Dr. Trace at 708 Church St., Evanston 60201.

Shirley Ann Roy, M.D., Chicago, has been elected to fellowship in the American College of Physicians. . . . **Harold A. Shafter, M.D.,** Park Ridge, an executive vice president at Lutheran General Hospital, has been named to the American College of Physician Executives. . . . **Irving M. Greenberg, M.D.,** Highland Park, has been elected treasurer of the Hektoen Institute for Medical Research of the Cook County Hospital. . . . **Sidney S. Lee, M.D.,** Chicago, has resigned as president of Michael Reese Hospital and Medical Center, Chicago, to accept an appointment as president of the Milbank Memorial Fund in New York, effective this fall. . . . **Roland Pritikin, M.D.,** Rockford, was recently honored at a Loyola University of Chicago Alumni Authors Exhibit reception for his contributions to the university's alumni collection of published works.

The Chicago Pathology Society recently elected the following slate of new officers: **John W. Mason, M.D.,** Oak Lawn, president; **Peter J. Dawson, M.D.,** Chicago, vice president; **Marshall H. Short, M.D.,** Chicago, secretary and **Gregorio Chejfic, M.D.,** Hines, treasurer.

REHABILITATION MEETINGS ANNOUNCED

The Department of Rehabilitation Medicine of the University of Health Sciences/Chicago Medical School and the Illinois Physical Medicine and Rehabilitation Society will sponsor a regional physiatric conference, 8:30am-5:30pm, September 15-16, at the Chicago Medical School. The program has been accredited for 11.5 hours' Category 1 CME credit. The conference is open to physiatrists and physicians treating patients with neuromusculoskeletal problems. The cost is $50 for physicians and $25 for residents. Registration checks should be made payable to the Illinois Society of Physical Medicine and Rehabilitation and mailed to the Department of Rehabilitation Medicine, Chicago Medical School, 3333 Green Bay Road, North Chicago IL 60064. Further information may be obtained through the Department at (312-689-8010).

The annual scientific meetings of the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation are scheduled for October 21-26 at the Boston Sheraton Hotel. Registration information may be obtained by contacting Creston C. Herold, Convention Coordinator, ACRM/AAPM&R, 30 N. Michigan Ave., Suite 922, Chicago, IL 60602 (312-236-9512).

ANXIETY STUDY

Rush-Presbyterian-St. Luke's Medical Center has announced a study for patients suffering from generalized anxiety disorder. The Department of Psychiatry will conduct an outpatient research medication treatment study. A five week treatment program will be offered for patients meeting entrance criteria. Physicians wishing to refer patients may contact Helen Jeffriess, R.N., clinical coordinator: (312-942-5342). ◀

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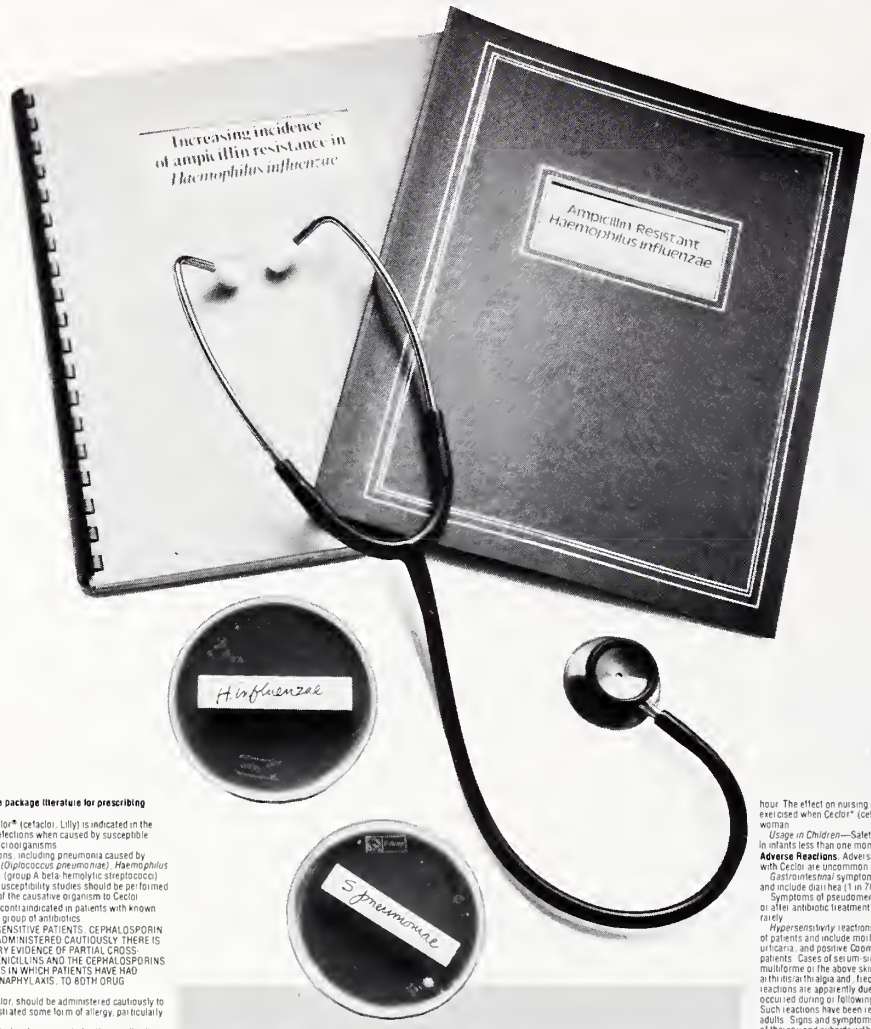
Other Programs: Adolescent Programs for Eating Disorders, Short Term Diagnostic Evaluation, and Sexual Abuse

For further information about Charter Barclay or admission procedures, contact:

Medical Director: Sanford I. Finkel, M.D.
Hospital Administrator: Edward Goldberg

CHARTER MEDICAL CORPORATION

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

I061782RI

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

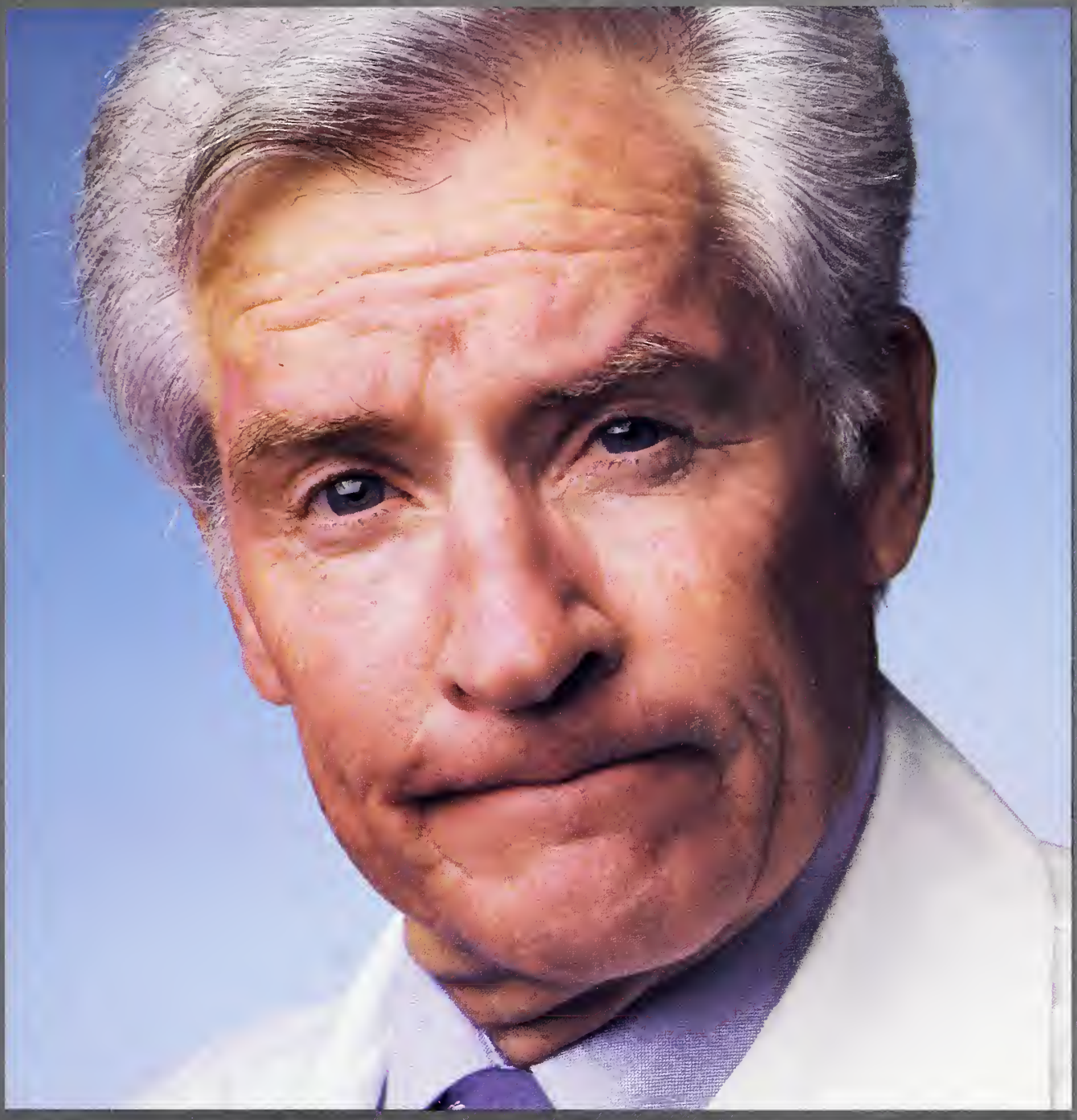
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A Little Like Noah's Ark

Dear Editor:

Mt. Hawley is what some would call a balanced community. Others might say that we are isolated or even dull. Truly we are off the beaten path. Lefty, the Apollo Cafe's gift to good conversation, stated it best with, "Mt. Hawley isn't the end of the world but I'm sure you can see it from here."

Our balanced community has always been a little like Noah's Ark—one of everything and most of the community needs were met without a lot of pushing and shoving for better position. Continuity was assured in that some family member usually took over the business or service as the oldster moved out to the pasture or to the philosopher's bench on the square.

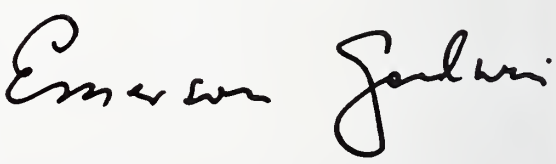
Balanced and comfortable, but the world changes. First the big supermarket and now it saddens me to report that a new office has been opened right on the square that plans to write insurance, sell real estate, and maybe even do a little branch banking. At this juncture, it's more rumor than reality, but rumor seldom has a calming influence.

The weather is a little warmer now. Sitting at my bench at the northeast corner of the square, which is really the crossroads of my world, I hear a lot of conversation. Our independent insurance agent, my nephew, who has taken over my real estate business, and the president of our federally insured bank, were discussing the rumored newcomer to the community. The conversation had two major headings. First, we've always offered the best deal, always competed. That's the American way, and we're in favor of that. The second area of discussion was that there ought to be a law, rule or regulation to keep other people from coming in here and taking over our business.

I assure you that my succinct characterization of the long and oft repeated conversation is not too far from the mark. Asa sat down next to me, stretched his legs out in front, tipped his straw hat back on his head, and warmed his face in the sun, not really expecting any conversation. I couldn't resist saying, however, that folks seem to talk competition and free enterprise and feel the need for the comfort of law and regulation.

Asa absorbed a little more sun, gazed out at the dynamic duo across the street, turned and said, "When competition is the way of the world, you have big losers and big winners. No one fancies being a big loser, and not everyone is sure they are going to be a big winner. Regulation and controls favor what's here now. Everybody gains or loses a little, but nothing big in either direction."

That was a long winded speech for Asa. It took probably 15 or 20 minutes of soaking sunshine before he could get up and amble off, but I think he called it right. To most folks the risk of being a big loser just isn't worth the slim possible gain of being a big winner. On this issue, there just isn't a best of both worlds. ◀



Sincerely,
Emerson Goodwins

Overweight and at risk. You know the problems.



Here's a sound medical solution.

As physicians, every one of us knows the consequences of obesity: cardiovascular disease... diabetes... hypertension... congestive heart failure... an increased risk of sudden death.

Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight—if, in fact, it is ever achieved.

The Institute for Health Maintenance (IHM) can help. Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss: THE RISK FACTOR OBESITY PROGRAM (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised supplemented fast with long-term behavioral and nutritional training.

Under the supervision of the IHM medical staff, patients lose weight safely and consistently over a period of weeks and months. They receive their total daily nutritional requirements from a low-calorie egg albumen formulation and a multivitamin tablet... a supplement they stay with until goal weight is achieved.

The success of the RFO Program has been significant. Over the past five years, thousands of patients have lost from 25 to over 100 pounds, with the average loss being 63 pounds. More important, 75%* of these patients have been able to sustain their new low weight levels with the help of our 18-month maintenance program.

Some have called the RFO Program "life-saving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors—one we at IHM can help control.

To learn more about us and how our program can safely benefit some of your patients, please contact one of our medical directors at a clinic near you.

*Data on file, Institute for Health Maintenance.

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ABSTRACTS OF ACTIONS

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

June 9, 1984

Arlington Heights Hilton
Arlington Heights, Illinois

Research Project

The Board considered a grant proposal from Dr. Sara Charles, a psychiatrist from Chicago, entitled "The Effects of Malpractice Litigation on Physicians." The survey is a first step in assessing physicians' perceptions of the impact of medical malpractice litigation on their professional practice and personal lives. The goal is to provide some of the essential data needed to proceed to a national study. The main advantage to the Society is the furthering of a process already begun, to be in the forefront of other medical societies in exploring the nature of medical practice in the current environment.

The Board agreed to support Dr. Charles' research project up to one-third of the cost from undesignated funds in the Educational and Scientific Foundation. Total cost of the project is budgeted at $7,700. Chicago Medical Society will provide $2,000 and ISMIE will be asked to provide the remaining funding support.

Leadership Conference

In keeping with the bylaws, an interim session of the House of Delegates can be called if determined to be necessary. When a meeting is not called, the option of conducting a Leadership Conference in lieu of a House meeting exists. The Board agreed to hold a Leadership Conference on November 10-11, 1984, at the Clock Tower Inn, Rockford.

Drugs and Therapeutics

The Board approved the following drug products for inclusion in the IDPA Drug Manual: DIABETA (Glyburide); MICRONASE (Glyburide); ORTHO-NOVUM (Ethinyl Estradiol Norethindrone); AZMACORT (Triamcinolone Acetonide) and STIMUZYME PLUS (Balsam Peru; Trysin Castor Oil).

The Board also recommended that the following drugs not be included in the Drug Manual: CALAN (Verapamil); LEVSIN (Hyoscyamine Sulfate); ANTIVERT (Meclizine HCL); TAGAMET 300mg/ml Syringe (Cimetidine HCL); LITHOSTAT (Acetohydraxamic Acid) and CALCIBIND (Cellulose Sodium Phosphate).

The Board reviewed appeals concerning LOZOL (Indapamide); VICODIN (Acetaminophen Hydrocodone Bitartrate) and recommended that LOZOL be included in the Drug Manual; and that VICODIN not be included in the IDPA Drug Manual.

Informational Items

The Board agreed to present a draft resolution for discussion at a joint meeting of the ISMS and AMA executive committees that would: (1) Remove the individual dues obligation from members of component societies; (2) Grant membership in the AMA to component society members; (3) Provide direct membership for only those physicians in the various federal services; and (4) Devise a mechanism for distributing the *JAMA* and other individual benefits, and report back to the AMA delegation for subsequent action.

Dr. John Standard, Medical Coordinator, Medical Disciplinary Board, gave a slide presentation on Medical Disciplinary Board activities.

The Executive Administrator reported on: (1) A request for a meeting from officers of Medical Protective; (2) Professional Liability Initiative; (3) IFMC; (4) SB495; and (5) The Medical Studies Act.

Other Actions

In addressing various other issues, the Board:

- Accepted the resignation of Dr. Alfred J. Kiessel, 7th District Trustee and elected the 7th District Caucus nominee, Dr. Boyd McCracken, Greenville, to fill the unexpired term.
- Encourages a physician review organization(s) to apply to be the statewide PRO and favors the designation of a physician review organization(s) as the statewide PRO.
- Approved the legislative positions delineated as amended in a list of House and Senate bills of primary interest to ISMS.
- Directed that AMA be asked to investigate new means of improving public relations efforts utilizing media and other mechanisms to promote a better understanding of the health care delivery system.
- Directed that the chairman act for the Board in setting *IMJ* advertising rates.
- Endorsed, pending review, a proposed program of the Departments of Public Aid and Children and Family Services to provide a managed system of care to treat approximately 30,000 children (wards of the State) in State facilities and foster homes.
- Accepted the:
 (1) Financial Statements for the period ended March 31, 1984;
 (2) May 17, 1984, IMPAC Collection Data Report; and the May 17, 1984, Membership Dues Payment Report;
 (3) Requests for changes in membership status with the addition of Dr. Richard W. Karraker, Moline, Rock Island County Medical Society, Fourth District, being granted retired status.
- Ratified appointment of ISMS members to one-year terms on the Society's councils and committees for 1984-85. Council chairmen appointed were: Drs. Fred Z. White, Chillicothe, Council on Economics; Eugene B. Loftin, Fairfield, Council on Education and Manpower; Alex Spadoni, Joliet, Governmental Affairs Council; Donal D. O'Sullivan, Oak Park, Medical Legal Council; Joseph D. Winterhalter, Jacksonville, Council on Medical Services; LeRoy Levitt, Chicago, Council on Mental Health and Addiction, and Albino Bismonte, Gurnee, Council on Public Relations and Membership Services.
 Appointed chairmen of committees reporting directly to the Board were: Drs. Terry F. Hatch, Urbana, Committee on CME Accreditation; Vincent A. Costanzo, Jr., Chicago, Committee on Drugs and Therapeutics; Fred Z. White, Chillicothe, Task Force on Financial Aid to Medical Students; Audley F. Connor, Jr., Chicago, Health Data Systems Committee; Robert M. Vanecko, Chicago, Committee on Health Planning; Allan L. Goslin, Streator, Task Force on Health Professions; L. Michael Newman, Evanston, Committee for the Impaired Physician; Anna L. Barlow, North Chicago, Committee on Insurance; Warren D. Tuttle, Harrisburg, Task Force on ISMS-Sponsored Insurance Programs; Donald Aaronson, Chicago, Ad Hoc Committee on Loss Prevention Education, and George J. Gertz, Chicago, Peer Review Appeals Committee.
- Granted the Illinois and Chicago Society of Physical Medicine and Rehabilitation membership on the ISMS Council on Affiliate Societies as well as the privilege of the floor in the ISMS House of Delegates effective at the next meeting.
- Ratified the following eight travel programs for ISMS members in 1985: South China Sea Cruise, Cairo to Kenya, Canadian Rockies, The Waterways and French Chateaux Country, British Isles, Scandinavia, Alaskan Air/Sea Cruise and China/Yangtze River.
- Approved the following meeting schedule for 1985:
 House of Delegates:
 April 26-28, O'Hare Marriott, Annual Meeting; November 1-3, Peoria Continental Regency, Interim Meeting or Leadership Conference.
 Board of Trustees:
 January 12-14, April 25-28, June 8-9, September 28-29, and November 1-3.

Appointments and Nominations

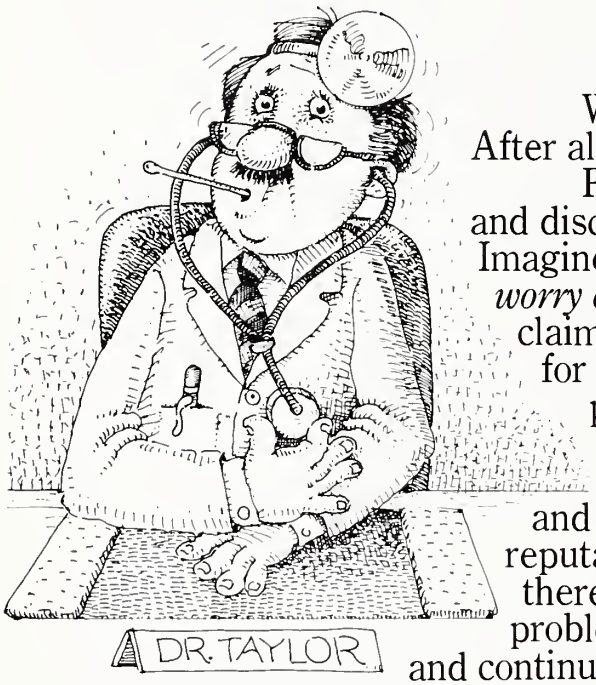
Various appointments and nominations were approved or ratified by the Board as follows:

- Nominated Dr. Irene Caruso, an ophthalmologist from Galesburg, as a nominee for the Medical Disciplinary Board and Dr. Jane Jackman, a family practitioner from Springfield, as an alternate nominee.
- Nominated Dr. Norris Dougherty for reappointment on the Statewide Health Coordinating Council.
- Ratified the selection of a committee consisting of Drs. Alfred J. Clementi, Robert P. Johnson and Harry A. Springer, to meet with Illinois Dental Society representatives in regard to SB 400 (Amendment to Dental Practice Act) to discuss guidelines for physicals performed by dentists.

Meetings

The Board set the next Board of Trustees meeting for September 15-16, 1984, at The Hamilton, Itasca.

Your practice very best



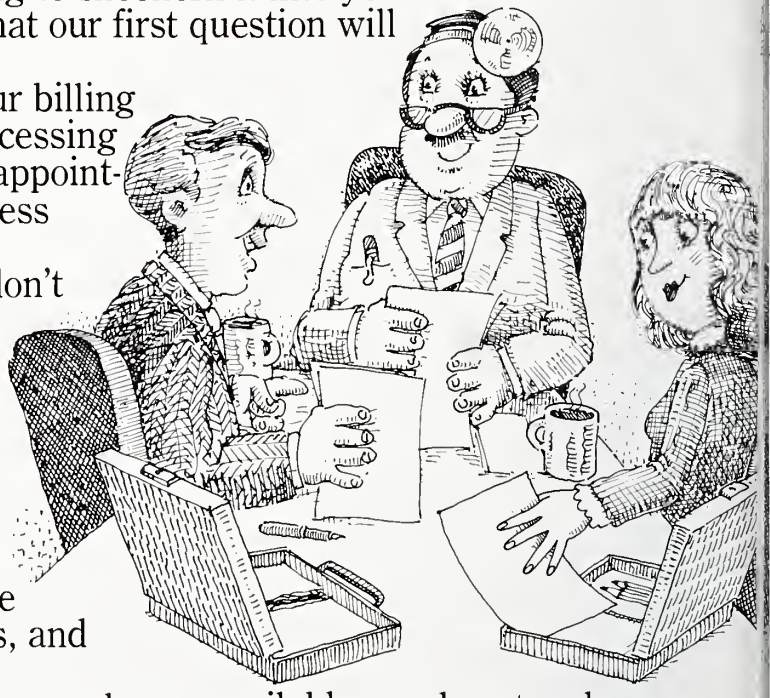
We feel it deserves a little special treatment. After all, it's your livelihood.

Phone or write Management Systems of Wausau and discover how smoothly your practice can run. Imagine your bills going out on time *without any worry or bother on your part at all.* Imagine insurance claims processed without problems, recall notices for follow-up care issued automatically, lists of patients and surgeries provided on demand.

Please be assured that we won't introduce new medicai management procedures and then bid you a fast farewell. We've built a reputation for outstanding service; we'll always be there to help. Our method is to diagnose your problems and then offer consultations, prescriptions and continual support to solve them.

DIAGNOSES Unlike typical computer management companies, we never start by presenting a service and trying to shoehorn it into your medical office. Actually, we offer so many services that our first question will be: "What do you really need?"

Then let's sit down and list your billing needs, collection needs, insurance processing needs, management reporting needs, appointment scheduling needs, general business needs, and medical reporting needs. Together, we'll also clarify what you don't need. Only then can an efficient, cost-effective program be chosen for your medical office.

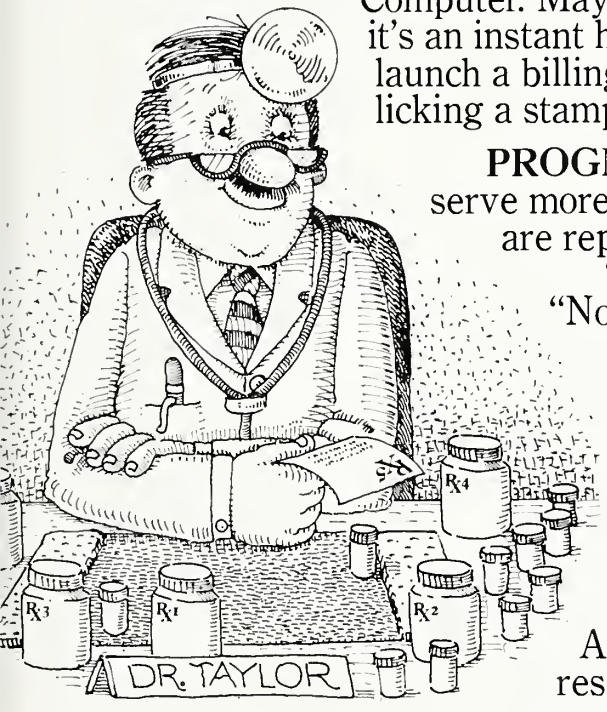


CONSULTATIONS In plain English, not computer or management jargon, we'll explain how to strengthen your financial control. For example, we can help you design more effective statements, collection notices, and routing slips.

Please remember that, while we are always available, we do not make excessive demands on your time. The idea is not to take time, but to save time. Our goal is to free your staff to devote more time to patients and less to paperwork.

deserves the of care.

PRESCRIPTIONS We prescribe only what you really need. Maybe it's a service bureau relationship to get your bills out. Maybe it's your own IBM Personal Computer. Maybe it's a sophisticated in-house system. Maybe it's an instant hook up with computers at Wausau that lets you launch a billing cycle without addressing an envelope or licking a stamp.



PROGNOSES Your prognosis should be excellent. We serve more than 400 medical offices in 30 states, and they are reporting results such as these: "Swifter cash flow." "Stronger financial control." "No month's end billing rush." "Improved collection rate." "Reduced number of lost charges." "Better use of staff." "Automated processing of insurance claims." "Computerized monitoring of patient care." "Automatic issuing of patient recall notices."

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Why not give your practice the attention it deserves? Phone today or mail the coupon for more details.

You'll receive a free *Medical Office Management Guide* filled with ideas you can use right now, including a workbook-like section for diagnosing your own needs. And there is no obligation of any kind.

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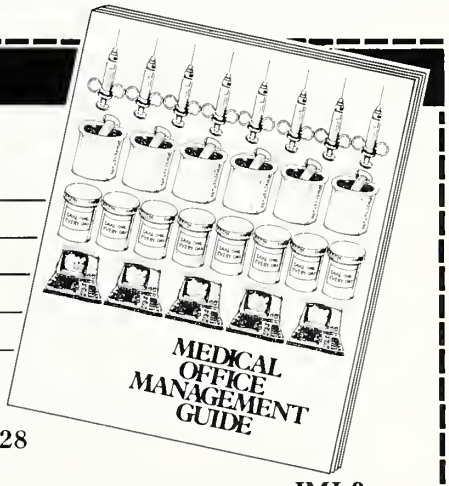
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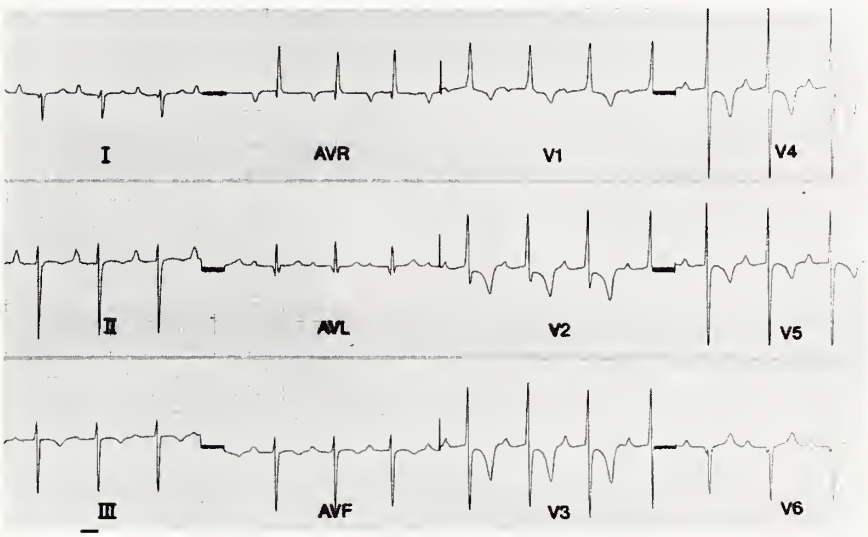
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IMJ-8

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a twenty-five year old man with known cyanotic congenital heart disease and Down's syndrome. The history was obtained mostly from his mother. He has complained of worsening dyspnea on exertion and marked fatigue. There has been some weight gain in the past two months. In the past, the patient had shown a sensitivity to digitalis. Therapeutic doses of digoxin caused sinoatrial block and second degree atrioventricular (AV) block. Physical examination showed a blood pressure of 115/90mmHg and a heart rate of 80 beats per minute. Lungs were clear. The cardiac exam showed a left sternal border lift but no thrills were felt. P_2 was increased. There was a loud S_3, and a grade 3/6 systolic crescendo descrescendo murmur heard best at the left lower sternal border. Clubbing of all fingers and toes was present. A chest X-ray showed an enlarged cardiac silhouette and pulmonary artery enlargement. The hemoglobin was 18.4g% and the hematocrit was 58%. This twelve lead ECG is obtained.



Questions:

1. The twelve lead ECG shows:
 a. Severe right ventricular hypertrophy.
 b. Marked right axis deviation.
 c. Sinus rhythm with first degree AV block.
 d. Right atrial enlargement.
 e. All of the above.

2. The following statement(s) is/are true:
 a. The above electrocardiogram is compatible with pulmonary hypertension.
 b. The trisomy 21 form of Down's syndrome (mongolism) is the most common human chromosomal aberration.
 c. Congenital heart disease is found in as many as 50% of the patients with Down's syndrome.
 d. The two most common cardiac lesions in Down's syndrome are ventricular septal defect and endocardial cushion defect.
 e. All of the above.

(Continued on page 121)

EXCLUSIVE

ILLINOIS GAZETTE

TALWIN® Nx...BUILT-IN PROTECTION AGAINST MISUSE BY INJECTION

Major Analgesic Reformulated

Now contains naloxone, a potent narcotic antagonist

Extra security added to proven efficacy and safety

No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ;* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

*Registered trademark of Ciba-Geigy Corp for tripelennamine.

Winthrop-Breon

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Talwin® Nx*

C IV Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

*In Illinois, TALWIN Nx is a Schedule II controlled substance and requires a triplicate prescription.

Please see following page for Brief Summary.

Talwin® Nx (IV)

Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone.

TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances. (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence.* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect.* Use cautiously in patients prone to seizures; seizures have occurred, though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery.* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions Usage with Alcohol.* See **Warnings.** *Carcinogenesis, Mutagenesis, Impairment of Fertility.* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C.* Should be given to pregnant women only if clearly needed. *Labor and Delivery.* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman. *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular.* Hypotension, tachycardia, syncope. *Respiratory.* Rarely, respiratory depression. *CNS. Acute CNS Manifestations:* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects.* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal:* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic.* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic.* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other.* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone is a specific and effective antagonist.

Please consult full product information before prescribing.

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Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Registration and Education

Actions of the Medical Disciplinary Board

ISMS has been advised that the following physicians have been disciplined by the Department of Registration and Education in the months of April and May.

- *Jerry Burger, P.A. (license #085-0009) and Clyde Wieland, M.D. (license # 036-034319):* On April 20, 1984, the licenses of Dr. Wieland and his Physician's Assistant were reprimanded and placed on a one year probation.
- *Gordon L. Richards, M.D. (licenses # 36-23938 and # 3-36-23938-1):* Effective April 27, 1984, the controlled substance license of Dr. Richards was suspended.
- *Paul E. Bourelly, M.D. (licenses # 36-28577 and #3-36-28577-1):* Effective April 27, 1984, Dr. Bourelly's controlled substance license was revoked. In addition, his license to practice was placed on probation for an indefinite period, and after June 1, 1984, he may not see, diagnose or treat patients except as may be related to a teaching or consulting position.
- *Philip Scott Zimmerman, M.D. (licenses # 36-59066 and # 3-36-59066-1):* Effective April 30, 1984, Dr. Zimmerman's controlled substance license was suspended for an indefinite period and his license to practice was reprimanded. He was also required to comply with certain agreements in order to continue to practice and to request a restoration of his controlled substance license.
- *John F. Lowney, M.D. (license #3-036-041032):* Effective May 18, 1984, the controlled substance license of Dr. Lowney was revoked in part and suspended in part. He cannot prescribe Schedule II Controlled Substances. At the end of his suspension, his controlled substance license will be placed on an indefinite probation. During that probation, his prescribing of controlled substances is limited.
- *William Relyea, M.D., (license #036-064841):* Effective May 22, 1984, the Department declared Dr. Relyea's license will remain in good standing subject to certain conditions.
- *Lorenzo Calosi, M.D. (license # 3-36-37538-1):* On May 22, 1984, the controlled substance license of Dr. Calosi was limited to hospital anesthesiology. On May 25, 1984, the Department withdrew its Complaint against Dr. Calosi, leaving his medical practice license in good standing.

(Source: Final Orders of the Director of the Department of Registration and Education)

Hospital Licensing Board

Due Process and Podiatrists

At its May 16, 1984, meeting, the Illinois Hospital Licensing Board received an Attorney General's Opinion on due process for podiatrists and other applicants for medical staff membership. The Opinion was in response to a request by the Board for an interpretation of its rules.

In summary, the Opinion stated that: (1) Podiatrists have the right to apply for hospital medical staff membership; (2) A hospital is not required to accept a podiatrist on its staff or to offer podiatric services; (3) There is a difference in the types of training and services provided by physicians and podiatrists; and (4) Initial applicants for medical staff membership, as well as current medical staff members, are to be afforded specific due process rights (delineated in the Opinion) and a fair hearing at every level of hospital review.

Due to a concern over the impact of these comments, the Board voted to consider asking the Attorney General for a clarification of his Opinion.

Non-Hospital Employees Working in Hospitals

The Board formed a subcommittee to create drafts of new regulations to deal with physicians' employees and other practitioners who provide patient care services in hospitals, but are not hospital employees or members of the medical staff. The intent is to require hospitals to have mechanisms to credential and monitor such personnel.

Use of "Disposable" Items

The Board voted to require hospitals to comply with manufacturers' instructions regarding the use and reuse of disposable equipment and supplies.

(Source: May 16, 1984 meeting of the Hospital Licensing Board)

From the Department of Public Health

New Hospice Licensing Law

On July 1, 1984, the Illinois Hospice Licensure Act took effect. The intent of the Act is to encourage the orderly development of hospice programs which provide supportive and palliative care to terminally ill persons and their families during the final stages of their illness and during dying and bereavement.
The Act and supporting regulations identify two types of programs which are subject to licensure:

- *Full hospice programs* are to provide physicians services, nursing services, social services, pastoral counseling, bereavement services and counseling, dietary counseling and short term in-patient care.
- *Voluntary hospice programs* need to provide only one of the services required of a full hospice. Also, to qualify as a volunteer hospice, the program must provide hospice services to patients regardless of ability to pay.

A full hospice is required to have a medical director who shall have the overall responsibility for direction of the care of patients and their families. The medical director shall also consult and work with patients' attending physicians. The duties of the medical director are spelled out in detail in the regulations.
Each volunteer hospice must have, as a minimum, a physician who serves as a medical advisor. The duties of the medical advisor are not specified in the regulations. However, it is anticipated that the physician would perform at least some of the duties performed by a medical director in a full hospice.
It should be noted that the regulations require that both types of hospices ensure that each patient has an attending physician.
The Illinois Department of Public Health, which is responsible for licensure of hospice programs, estimates that there are 40-50 organizations in the state which, as of July 1, may be subject to licensure. The Department will issue provisional licenses to these facilities. Provisional licenses will be valid until July 1985. Prior to that time, IDPH will survey the facilities for purposes of regular licensure.
More information may be obtained by contacting: Division of Health Facilities Standards, Hospice Licensure Unit, IDPH, 525 West Jefferson, Springfield, IL 62761; 217/785-2628.

(Source: Correspondence from Joseph L. Voss, Administrator, Ambulatory Health Programs, Division of Health Facilities Standards, IDPH)

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Physician Ownership Makes A Difference!

Participate? Me?

By Pedro A. Poma, M.D./Melrose Park

"I don't know how you can do it," said a friend of mine while we were reviewing charts at a nurses' station. When I stared at him, he proceeded: "I mean all those meetings, those committees and those other duties you much have now with your increasing involvement with the medical society."

Describing my satisfaction as a member, I responded that if more physicians shared the load, those now engaged in Society activities could attend fewer meetings and volunteer fewer hours. If most of us would do our share, our Society's achievements might be easier and more rewarding.

Obviously, involvement in our medical organizations implies more time spent in meetings and more hours taken away from our practices, our families, other general societal obligations and leisure. This commitment also implies that some of our schedules might be shifted (no office hours or elective procedures at certain hours). We're likely to experience some emergency shifting (running) from meeting places to our offices or hospitals, and to have less time with our loved ones and for our special "pet" projects. We also might need to return the favors of those colleagues who cover for us when we work at medical society affairs.

Physicians who become active in medical society affairs are often labeled "politicians," a label that often has ugly connotations. But one needn't be a "politician" or wish to become one in order to become involved. The task is immense, and the futures of medicine as a profession and American health care in general are at stake. The success of each requires immediate attention and the participation of every able person.

The Challenge

There is a time in life when we must return to the world what the world has given us. Some feel this urge with the intensity similar to their feelings about teaching, orienting and directing students, residents and younger colleagues. It is the same sense of duty we respond to when we return to our parents what they shared with and provided us or when we give to our children what was given to us.

There is a time to return to society as a whole what it has done for us. A time to better society and leave "a better world for the next generation." This time is the seventh stage of Erikson: generativity versus self-absorption.[1] Everyone has an opportunity to participate. Participation, the act of sharing, enjoying with others, taking part in activities, (according to Webster)[2] is giving in a mature way.

Our profession is besieged by many forces. Earlier, many attempted by several means to tarnish, destroy or share in the aura of the physician image. The desire to exercise independent professional judgement in the clinical management of patients, to assume adequate and proper care for patients despite their ability or inability to pay and to maintain and to advance the level of American medicine, have been essential goals of physicians. However, the attempts of physicians and organized medicine to reach these goals have sometimes been attributed by some as actions to protect their "turf," to prevent competition, and especially to inflate personal incomes.

Today, the more traditional members of the health team—and even some newer members—wish to have admitting, diagnostic and prescribing privileges. In addition, other individuals often attempt to share part of our supposedly large incomes by bringing frivolous suits and other harassments. However, these people apparently don't realize that most physicians' incomes are no higher than the incomes of

members of other professions and probably lower than incomes of other persons when the length of education and training, dedication, responsibility, continuous drive for professional improvement and length of working hours are compared.

Furthermore, the public expects physicians to perform miracles. Many people don't take care of themselves. They abuse themselves with food, tobacco, alcohol and other dangerous substances; they take part in dangerous activities (auto racing and dangerous sports). They are not interested in preventive measures. However, they tend to blame their physicians when they do not recuperate quickly.[3]

Sometimes physicians are even blamed for social problems that our profession cannot solve (poverty, unemployment, etc.). But our progress is often ignored. The average American life span is longer with every new set of statistics. Most illnesses that caused death early in this century are now curable. Most children born here achieve adulthood; 25% of the population is older than 65, and this proportion continues to increase. Medicine performs miraculous cures and procedures (including transplantation and the insertion of artificial organs). More people who might have died a few years earlier are alive and stay alive (including the newborns of second trimester pregnancies). More people born with what were previously considered severe defects survive to contribute to society. And, terminal care (the care of persons who will die from their illnesses) has also become extremely prohibitive economically.

Still, the public considers medical care a right. Most voting taxpayers say they want to decrease the size of health care expenditures. But they give little consideration to economic restrictions when their health or their loved ones' health is at stake. Hospitals are becoming better and safer, but increasingly more expensive. This country expends $286 billion dollars on health care annually (the second largest item of the national budget). All of these bring more regulation and concern from corporations, government and the public—all of which are inclined to request more regulations which, in turn, increase costs to a greater degree.

Today, hospitals are competing with their physicians for patients by opening peripheral offices and clinics (some even in the hospital buildings). There are more practicing physicians in this country than ever before, but because of increasing expenses (of which malpractice premiums represent a high share), it is becoming more difficult for new graduates to open new practices. An increasingly large proportion of physicians are employees; more patients are becoming patients of a corporation rather than individual physicians' patients. And even more pressures on physicians are anticipated.

Furthermore, it may be difficult for physicians to unite. Persons commonly become physicians because of altruistic reasons and an interest in the sciences.[4] Obviously, the benefit of counselling, comforting and alleviating another human being of his/her health problem is a great reward in itself. But, there are other common attractions of the profession of medicine, including autonomy—the freedom of choice over type of specialty, place and type of practice (self employed vs. employed, solo vs. group, etc.). Medicine seems exciting and powerful, especially to the uninitiated. Individual physicians are still held in high esteem. Distressed persons come to physicians for relief, comfort and understanding, reassurance, determination of what the causes of their physical problems are, and the hope of eliminating the ailments.[5]

Individuality, perfectionism, and competitiveness are all characteristics encouraged throughout preparation and education which might decrease openess and peer support. Little energy is left for more intimate social interchange.[6]

Young physicians, de-sensitized and seeking to cope, learn to suppress emotional responses so that productivity can be increased. This defensive denial and detachment transferred to their personal lives precludes development of intimacy and leads to isolation—a negative solution to a crisis. The continued stress of the long, involved educational process prevents adequate evolution to adult levels of Erikson's stages, and acts to stagnate development. Continuing difficulties interfere with the adequate resolution of crises.[6]

Later, going along with the expected physician image, many physicians might not communicate any information about themselves on a personal level. They might even begin to believe that they are invincible and indestructible. Some might have to unlearn some patterns which have been reinforced for several years (or even decades) in order to share with others and to participate along with their colleagues.

The Response

D. Webster said, "There are many objects of great value to man which cannot be attained by unconnected individuals, but must be attained, if at all, by association." Becoming a member of organized medicine must be considered a basic duty. That the Chicago Medical Society became the largest county society last year seems to imply that many of our brother and sister physicians feel this way. However, not all physicians are members and this is frustrating to some members who feel they carry responsibility for those who aren't members.

There are multiple medical societies, and new ones continue to be formed. There are organizations according to specialties (family practitioners, surgeons, etc.); subspecialties (oncology, cardiology, etc.); types of practice and types of employer (universities, groups, etc); gender; country of origin, race and secondary language spoken (Indian, Lithuanian, Greek, etc.); region or state (Midwest, Central, etc.); and so on, with multiple combinations thereof. Each individual organization offers specific benefits to its members, including the special sense of identity, of belonging, of comradeship and friendship.

However, these organizations have specific, limited goals. For example, some problems of a pediatric neurologist are not usually

similar to those of a gerontologist, nor are the problems of an obstetrician common to those of a thoracic surgeon. Notwithstanding, because all of the specialists and subspecialists are physicians, they share the same basic problems that affect all physicians—patient-physician relationships, alternatives to management, governmental and corporate interference in medical care, confidentiality, etc.

County and state societies and their federation—the American Medical Association—deal mainly with common problems and interests that affect all physicians and their patients. Although the AMA, in association with the other specific organizations or by itself, also deals with the other more specific problems, it is the only medical association which deals with the basic problems affecting physicians and their patients alike.

Not everyone who is a member becomes a member for purposes of comradeship or to address the common issues facing physicians. Some become members because of ancillary benefits (*i.e.*, malpractice insurance and other benefits). However important it might be for the organization to have more members, non-participation deprives the organization, and the public in general, of ideas and attitudes that these individual physicians possess and fail to share.

Meanwhile, these physicians also allow others to do their work for them, or even worse, decide for them on issues and take directions which they might totally oppose. I don't believe they can blame the organization for those directions on important issues if they did not let their opinions be known.

Non-participating is like having the right to vote and not exercising it. Every year many people who legally reside in this country become U.S. citizens just to be able to vote. The right to vote is the only difference between a legal resident and a U.S. citizen. Being a member and not participating is like not using a right given to us by our founding fathers. Not being a member is having others take on our responsibilities—having others do our work for us.

Finally, participation and involvement with the medical society can be fun. Most meetings are scheduled during off hours. As other members of the committees are also practicing physicians, they understand when one has to leave a meeting for an emergency.

Variation adds spice to our lives. Many activities of the society are quite different from the everyday practice of medicine. Often meetings are informative and enlightening, giving the participants a new understanding of the medical world. These activities introduce new and interesting people, who bring new insights, new information, new viewpoints, new perspectives. Participating is not a one-way street; it benefits the society, the members and the participants themselves. My friend is seriously considering participating. How about you? ◀

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Pedro A. Poma, M.D., Melrose Park, is a board certified obstetrician/gynecologist affiliated with Foster G. McGaw Memorial Hospital in Maywood and both Gottlieb Memorial and Westlake Community hospitals in Melrose Park. He is a clinical assistant professor, Loyola University of Chicago and an assistant professor, Rush Medical College. Dr. Poma is a fellow of the American College of Obstetricians and Gynecologists, Central Association of Obstetricians and Gynecologists, Chicago Gynecological Society, American College of Surgeons, and International College of Surgeons. A member of the ISMS Board of Trustees and chairman of the ISMS Publications Committee, Dr. Poma is an ISMS alternate delegate to the AMA. He is a trustee of the Chicago Medical Society and past president and secretary of the CMS West Side Branch.

Organized Medicine What's In It For Me?

Plenty. When you join the Illinois State Medical Society, your county medical society, and the American Medical Association, you're entitled to the usual complement of publications, insurance programs and travel packages. But there's more to organized medicine than that.

When you become a part of organized medicine, you add "strength in numbers" credibility to advocacy efforts on behalf of the profession. Legislators and other public policy makers pay more attention when they know the organization they're dealing with represents the majority of physicians.

And when groups such as ISMS, the AMA and county medical societies are able to pool their resources, the physician member of each organization gets more value for his or her dues dollars.

Physicians who don't join organized medicine put a burden on those who do. Non-members reap the benefits of organized medicine's activities, without contributing to the support of its efforts.

If you're already a member of organized medicine in Illinois, your continued support is appreciated. But we'd like your help in contacting non-member colleagues to explain to them why their participation is important.

Please detach the post card opposite this page and give it to a non-member today. Tell him or her to complete it and drop it in the mail. And remind your colleague that it's important to bear a share of the burden of protecting the physician's right to practice the best medical care possible.



Sincerely,
Robert C. Hamilton, M.D.
ISMS President

How Much Difference Can One Person Make?

A big difference.

The success of the ISMS malpractice initiative requires a commitment from each ISMS member.

We have some distance to travel yet, but thanks to the many ISMS members who made the effort to contact their legislators and support the ISMS malpractice initiative this spring, there's genuine hope for legislative reform in Illinois.

We were not as successful as we would have liked with respect to professional liability in this session. But the voice of medicine was heard in Springfield.

As you are no doubt aware, the ISMS professional liability package was routed to subcommittee by both the House and Senate Judiciary Committees in early May. That action effectively eliminated any hope of relief in the spring session. But upon the Society's request, both committee chairmen stated that subcommittee hearings would be held.

The assistance of the many members who contacted their senators or representatives on this issue is greatly appreciated. We've received several comments on the "flood" of phone calls and mailgrams to Springfield from physicians across the state. There is no doubt that our most effective tool is the individual physician communicating with his or her legislator.

"For want of a nail," the opening volleys of the ISMS legislative initiative might have fallen on deaf ears. But we have miles to travel before balance is returned to the system. For that reason, I'd like to ask each member to consider becoming a part of the ISMS legislative team.

Completing and returning the postcard on the facing page will enable you to become an ISMS Key Contact—our strongest ally in legislative reform. I urge you to complete that postcard and return it to the ISMS offices today.

And we have another request of you. A number of senators and representatives on both sides of the aisle sponsored the ISMS professional liability package and deserve a letter of thanks. Those sponsors and their addresses are listed at the bottom of this page. If your legislator is among them, please consider writing a personal letter of thanks. Their support was vital in launching the ISMS malpractice initiative.

Again, many thanks for your help.

Sincerely,

A. J. Clementi MD

Alfred J. Clementi, M.D.
Chairman
ISMS Board of Trustees

Sponsors of the

ISMS Legislative Package

Senators

Sen. Terry Bruce (D-Olney)
State House, Room 323
Springfield IL 62706

Sen. Aldo DeAngelis (R-Chgo. Hts.)
State House, Room 309-F
Springfield IL 62706

Sen. Prescott Bloom (R-Peoria)
State House, Room 307
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Representatives

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Additional MRI information on page 111.

IMJ

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Pre-Existing Medical Problems

Ambulatory Surgery

By Herbert E. Natof, M.D./Arlington Heights

The growth of ambulatory surgery has raised important questions about the proper selection of patients. This prospective study covers 17,968 patients who received care at a freestanding ambulatory surgical center over a period of approximately 5.5 years.

A total of 1,984 patients in our surgical population had some form of pre-existing systemic disease. Patients manifested a broad spectrum of medical problems. These included hypertension, heart disease, chronic pulmonary disease, diabetes mellitus and asthma. The incidence of complications was no higher in our patients with pre-existing disease than in those patients with no systemic disease. We have experienced neither cardiovascular collapse nor death at the center.

The ambulatory surgical mode is a preferable setting to carry out some surgical procedures in properly selected patients with pre-existing systemic disease.

This review investigates the relationship between pre-existing systemic disease and complications in a population of selected ambulatory surgical patients. An earlier review by this author reported on overall problems and complications, concluding that many surgical procedures could be performed with equal safety in an outpatient and hospital inpatient setting.[1] This report focuses on the experience of ambulatory surgical patients with pre-existing disease.

Our freestanding ambulatory surgical center is physically and organizationally separate from a hospital. This study covers the 17,968 patients who received service at this facility between April 17, 1974 and December 31, 1979. A summary of the operative procedures performed is presented in Table 1, and a profile of the surgical population is presented in Table 2. The number of patients over the age of 65 was limited by the fact that the Medicare law did not provide reimbursement to freestanding ambulatory surgical centers during the period of this review. Our center was part of a two year demonstration study sponsored by the Department of HEW, and did render service to Medicare patients during that period.

For the purposes of this review, a major complication is defined as an untoward episode or adverse response with potential for serious harm associated with ambulatory surgery. It includes hemorrhage, infection, serious anesthetic complications, any medical problem requiring hospitalization and other potentially harmful occurrences.

A minor complication is defined as an uncomfortable or unpleasant episode with little or no potential for serious harm related to ambulatory surgery. Minor complications include transient episodes of nausea, vomiting, sore throat, dizziness, muscle ache, and headache.

Methods

All patients receiving care are given a prepaid postcard before discharge. They are instructed to hold the postcard for two weeks and then complete the inquiry regarding complications. When a patient reports a complication, further information is obtained from the surgeon and the patient to complete a formal summary. Every patient who fails to return the postcard is called within one month of the date of surgery.

All complications occurring during the intraoperative and recovery

Table 1
25 Most Common Surgical Procedures

1. Dilatation & Curettage—2055
2. Laparoscopic Tubal Coagulation—1730
3. Adenoidectomy—1449
4. Myringotomy—1414
5. Tonsillectomy & Adenoidectomy—1334
6. Excis. Soft Tissue Mass—1242
7. Excis. Skin Lesion—1106
8. Inguinal Hernia Repair—880
9. Cystoscopy—765
10. Metatarsal Osteotomy—472
11. Bunionectomy—462
12. Augmentation Mammoplasty—448
13. Arthroplasty (Digits)—395
14. Vasectomy—389
15. Tonsillectomy—364
16. Submucous Resection—288
17. Dental Surgery—248
18. Eye Muscle Surgery—235
19. Closed Reduction Nasal Fx—223
20. Excis. Neuroma—202
21. Scar Revision—182
22. Nasal Polypectomy—164
23. Laryngoscopy—152
24. Diagnostic Laparoscopy—148
25. Cervical Conization—146

All Other Procedures—1475

Only the primary operation was tabulated if more than one procedure was performed.

room periods are recorded at the time of the incident. This prospective plan for gathering data has resulted in a 99.8% follow-up of all patients.

Presence of pre-existing medical problems was established through review of every patient chart. This included a review of the screening medical history completed by the patient, the surgeon's history and physical exam and the anesthesiologist's medical review.

Results

A total of 1,984 patients in an overall surgical population of 17,968 patients reported pre-existing medical problems.

The most common disease entity was hypertension, found in 560 patients. At surgery, 432 of these patients were receiving one or more antihypertensive drugs and 179 patients had at least one additional coexisting medical problem. Three major complications occurred in the hypertensive group; (see Table 4) none was directly related to the high blood pressure.

A history of asthma was reported by 373 patients, 226 of whom were under treatment with specific asthma ameliorating drugs. More than 80% of the patients in tnis group were under the age of 40. There were 83 additional patients who manifested some form of chronic pulmonary disease (emphysema, chronic bronchitis, bronchiectasis, and post-surgical loss of lung tissue).

Heart disease was reported by 229 patients. Of these, 112 had a history of coronary artery disease, including 38 patients who had experienced one or more myocardial infarctions. This group also included patients who had coronary bypass surgery and patients with implanted pacemakers.

There were 44 patients with congenital heart disease, and the remaining patients manifested diverse cardiac pathology such as rheumatic valvular disease, prolapse of the mitral valve, Wolf-Parkinson-White syndrome, other arrhythmias, and non-specific myocarditis. Of the patients in the cardiac disease group, 97 were currently receiving medications (cardiac glycosides, beta blockers, diuretics, anti-arrhythmics, vasodilators, and anticoagulants). There were two major complications (see Table 4) among the 229 patients with heart disease; none was related to the complication.

There were 107 patients with diabetes mellitus, ranging in age from four to 79 years old. Forty-seven diabetic patients were insulin-dependent. More than 50% of these patients had at least one additional coexisting medical problem. There was one major complication within this group.

Some form of central nervous system disease was reported by 180 patients. Manifestations included cerebral palsy, Down's syndrome, multiple sclerosis and mental retardation.

The remaining patients had pre-existing renal, hepatic, gastrointestinal, endocrine, hematologic, allergic, arthritic and systemic malignant disease states.

The incidence of major and minor complications showed no statistical difference between patients with a history of pre-existing disease and patients with no disease (Table 3).

Twenty-three major complications occurred in the group of 1,984 patients with pre-existing disease (Table 4). Each of these was carefully reviewed. There was a direct cause and effect relationship between the complication and the patient's pre-existing disease in only three cases (Cases 1, 2, and 3). In six additional cases, there was a possible, but unlikely, relationship (Cases 4, 5, 6, 7, 8, and 9). There was no apparent relationship in the remaining cases.

The American Society of Anesthesiologists has established a simple classification for estimating the general preoperative health of a surgical patient. Physical status one patients are judged to be free from systemic disease and in good general health. Physical status two patients have moderate systemic disease. Physical status three patients have serious systemic disease and are generally viewed as presenting an increased risk.

There were 198 major complications in the 17,326 patients classified physical status one and two. There were four major complications in the 642 physical status three patients. There was no evidence that the presence of serious

Table 2
Profile: Ambulatory Surgical Population of 17,968 Patients

Sex			
Males: 42%			Females: 58%
Age:			
0-19	20-39	40-59	60 +
46%	34%	16.5%	3.5%
Anesthesia:			
General	Intravenous Analgesia		Local
71%	17.5%		11.5%

Table 3
Complications

No Pre-existing Disease	Pre-existing Disease
Patients	
15,984	1,984
Minor Complications	
4.0%	3.7%
Major Complications	
1.12%	1.16%

Fisher Exact Test, $P > .05$. No statistical difference between the two groups.

systemic disease in our patient population increased the incidence of complications.

Although this study did not focus upon any specific age group, the complication data in the age group "60 years and older" was very interesting. There were 629 patients in this age group, which included 262 patients with pre-existing systemic disease. This was the highest incidence of pre-existing medical problems of any age group. This age group, as expected, also had the highest incidence of patients classified physical status three. There were five major complications in this age group. This was the lowest incidence of any age group.

Discussion

Hemorrhage, infection, anesthetic complications, and other serious problems can occur in so-called "minor" surgery. Serious morbidity and death have occurred in many patients scheduled for surgical procedures usually characterized as "minor."[2]

The author is personally aware of six deaths that occurred during the past several years in both free-standing and hospital-affiliated ambulatory surgical centers. However, there was no objective evidence in any of these cases to relate the catastrophe to the ambulatory surgical concept *per se.*

Each of these episodes would have been just as likely to occur in the hospital inpatient setting if the same patient, surgical team, and circumstances were involved. Furthermore, there was no reason to believe that in any of these cases the final outcome would have been different had the surgery been performed within the hospital rather than the ambulatory setting.

The experience gained over the past 9½ years has demonstrated that most properly selected patients with a broad spectrum of pre-existing medical problems can safely undergo ambulatory surgery.

One of the most important factors in preventing complications in the ambulatory setting is prudent patient selection. Brown has stated, "Never has the role of anesthesiologist as physician been more challenged than in outpatient evaluation."[3]

The cornerstone of our selection process is preoperative communication between surgeon and anesthesiologist for all patients with special problems. This communication is a simple process, usually conducted by telephone while the patient is in the surgeon's office. In many problem cases, the patient's primary care

Table 4
Major Complications in Patients with Pre-existing Disease

Case #	Surgical Procedure	Age/Sex	Pre-Existing Disease	Complication
1	Dental Surgery	7/M	Tracheal Stenosis	Subglottic Edema
2	Myringotomy	11 mo/F	Microcephaly	Respiratory Arrest During Anesthesia
3	Diagnostic Laparoscopy	36/F	Asthma	Asthmatic Attack—Postop
4	Hernia Repair	9 mo/M	Hx. Pulmonary Fibrosis	Respiratory Tract Infection
5	Release Adhesions Ear Canal	51/M	Hypertension	Severe Vertigo
6	D & C	43/F	Hx. Thrombophlebitis and Pulmonary Emboli	Wheezing and Chest Pain
7	Alcohol Nerve Block	66/F	Diabetes Mellitus, Retinal Vein Thrombosis	Poor Appetite and Wt. Loss
8	Myringotomy	9/M	Peptic Ulcer	Emesis, Exacerbation Ulcer Symptoms
9	Nasal Polypectomy	62/M	Hypertension	Syncopal Episode
10	Nasal Polypectomy	64/M	Polycythemia Vera	Perforation Cribiform Plate
11	Laparoscopic Tubal Sterilization	30/F	Chronic Bronchitis	Severe Anxiety Symptoms
12	Adenotonsillectomy	5/M	Ventric. Septal Defect	Postop Bleeding
13	D & C	24/F	Cardiac Arrhythmias	Cervical Bleeding
14	Excision Scars	12/F	One Functioning Kidney	Wound Infection
15	Blepharoplasty	43/M	Hx. Hepatitis	Postop Bleeding
16	Submucous Resection	15/M	Petit Mal Epilepsy	Postop Bleeding
17	Adenotonsillectomy	9/M	Asthma	Postop Bleeding
18	Diagnostic Laparoscopy	33/F	Asthma	Chemical Phlebitis
19	D & C	48/F	Hypertension	Perforation of Uterus
20	Tonsillectomy	22/M	Hx. Peptic Ulcer	Postop Tonsil Bleeding
21	Myringotomy	9/F	Retardation, Seizures	Respiratory Tract Infection
22	Submucous Resection	19/M	Asthma	Postop Bleeding
23	Augmentation Mammoplasty	32/F	Asthma	Postop Bleeding

and specialty physicians are also consulted by telephone in order to provide cohesive medical care and minimize duplication of costly medical tests. This simple mechanism provides the anesthesiologist with valuable information necessary for patient selection and subsequent management, if he or she is deemed a suitable ambulatory candidate.

In addition to the preoperative office screening phase, every patient scheduled for surgery with general or intravenous analgesia is examined and interviewed by their anesthesiologist on the day of surgery.

Patients with special medical problems are evaluated on an individual, case-by-case basis. The decision to accept a patient is based upon a review of all factors, including the proposed surgery, anesthesia required, pre-existing medical problems and degree of physiologic disturbance, need for special postoperative care, perceived ability of the patient and his family to manage in the home environment, and advantages or disadvantages of alternate surgical settings.

Addendum

Since compilation of the data in this article, we have rendered service to over 30,000 patients. There has been one episode of ventricular fibrillation occurring in a 59-year-old male with a long history of alcoholism and recent onset of hypertension. The resuscitation process was carried out promptly and smoothly, and the patient was defibrillated without difficulty. However, there is evidence that some central nervous system damage was experienced by the patient.

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Clinical, Epidemiologic and Laboratory Correlation

Pleuropulmonary Radiographic Abnormalities in Rheumatoid Arthritis

By Bruce M. Rothschild, M.D., Randall L. Scott, M.D., Martin L. Pinstein, M.D., Frank D. Parks, M.D., Carolyn M. Chesney, M.D., D. David Pifer, PhD, and K. Michael Peddecord, PhD./Kansas City, Memphis, and San Diego

Clinical, laboratory, and radiographic analysis of a series of patients with definite or classical rheumatoid arthritis (RA) was compared with age, sex-matched controls. A correlation of certain RA subgroups with erosive joint disease and Raynaud's phenomena was identified. The difficulty in documenting statistical significance of pulmonary radiographic changes was analyzed and required sample size determined. Modification of pulmonary pathology by collagenase and elastase inhibitors could not be documented. Although radiologic evidence of obstructive lung disease was found as frequently as in controls, it did not correlate with smoking habits in rheumatoid patients and may have another etiology in patients with RA.

Pulmonary manifestations of rheumatoid arthritis (RA) have been a source of discussion since 1948 when Ellman and Ball[1] first commented on an apparent clinical association. The frequency of lung involvement in RA has been a source of controversy.[2-18] The results of radiographic,[9,10] functional,[19] and anatomic[14,17] studies have been difficult to reconcile. Previous studies of the role in RA of elastase and collagenase and their inhibitors have been inconclusive.[20,21] Since perturbations of elastase and collagenase inhibitors have been noted in association with pulmonary pathology (*i.e.*, emphysema),[22-26] it was of interest to examine their levels in RA patients with lung disease. This study was initiated to determine the relative frequency of pulmonary involvement in patients with RA, to establish their correlation with selected clinical and laboratory parameters, and to establish the necessary sample size to establish statistical significance.

Method

The current study correlated clinical and radiographic analyses of a series of 51 consecutive patients with definite or classical rheumatoid arthritis[27] and age, sex-matched, non-rheumatoid patients seen during the same time interval in affiliated clinics. Chest radiographs of patients and controls were evaluated by two individuals in the double-blind model. The single instance of non-uniform assessment was resolved by a third examiner. Pleuritis was defined on the basis of radiologic evidence of pleural thickening, blunting of the costophrenic angle, or presence of pleural effusion. Obstructive lung disease was diagnosed radiologically if diaphragmatic flattening and increased retrosternal air space were present.

Fibrin degradation products (FDP) were determined by latex agglutination (Thrombo-Wellco test) on thawed serum samples. Plasma alpha-2-macro-globulin and alpha-1-antitrypsin were assayed by radial immunodiffusion (Mancini technique) after reaching the diffusion end point.[28] The erythrocyte sedimentation rate was assessed by the Westergren technique.[29] Rheumatoid factor was assayed by latex fixation and antinuclear antibody with a fresh frozen rat liver substrate.[30]

Chi-square, Fisher exact test,

Table 1
Frequency (%) of Pulmonary Radiographic Findings in Rheumatoid Arthritis and Control Groups

Abnormality	Rheumatoid	Control
None	66.6	82.3
Pulmonary fibrosis	9.8	2.0
Pleural effusion	5.9	2.0
Fibrosis and effusion	2.0	0
Pulmonary nodules	5.9	0
Caplan syndrome	0	0
Pulmonary hypertension	0	0
OLD	9.8	13.7

analysis of variance, and regression analysis tests of significance were performed. Sample size requirements were estimated using the method of Fleiss.[31]

Results

Pathologic pulmonary roentgenographic findings were noted in 33.4% of patients with rheumatoid arthritis and 17.7% of controls (Table 1). Radiographic findings considered characteristic of rheumatoid lung disease (pulmonary fibrosis, pleural effusion, rheumatoid nodules) were found in 23.5% of patients with RA and only 4% of controls. Obstructive lung disease (OLD) was equally represented in both groups (9.8% of RA and 13.7% of controls).

Age, activity and duration of disease, erythrocyte sedimentation rate, and presence of subcutaneous nodules (Table 2), rheumatoid factor, antinuclear antibody (Table 3), and symptoms of pleuropulmonary disease (dyspnea and pleuritis) varied independently of chest roentgenographic findings.

Raynaud's phenomenon was significantly more common in patients with pleural effusion or pulmonary nodules (Table 2). Erosive joint changes were more frequently observed in patients with pleural effusion or OLD (Table 3). Alpha-1-antitrypsin, alpha-2-macroglobulin, and fibrin degradation levels (Table 4) varied independently of chest roentgenographic findings.

Discussion

The frequency of the various types of pleuropulmonary pathology in this study was comparable with that previously noted in other studies of RA.[2,9,14-16] Although chest radiographic evidence of pleuropulmonary pathology was more common in patients with RA, ability to demonstrate statistical significance again proved elusive.[2,9,14-16] The inability to demonstrate a statistically significant increase in frequency of pulmonary radiographic changes in rheumatoid arthritis appears to be a manifestation of the low frequency. Beta (β) or type II error defines the frequency of accepting the null hypothesis (that there is no significant difference between groups) when the alternative hypothesis is true. It reflects the risk of missing significant intergroup variation. The β group is inversely proportional to the alpha (α) error (risk of falsely rejecting the null hypothesis). The alpha level is fixed by convention, at 0.05. Therefore, to decrease the β error, one must increase the size of the groups undergoing evaluation. On the basis of the present study, the number of patients required for a given β error can be calculated.[31] Power is a statistical term defining the assurance ($1-\beta$) that a β error has not been made. Assessment of statistical significance of pulmonary radiographic findings would require a study group composed of at least 764 patients, if a β error of 20% were to be accepted. Even with 996

Table 2
Clinical Profile of Patients with Rheumatoid Arthritis According to Type of Pleuropulmonary Pathology

Parameter	Controls	Pulmonary Fibrosis	Pleural Effusion	Pulmonary Nodule	OLD	P
Age ($\bar{x} \pm$ s.d)	54 ± 10	60 ± 6	60 ± 3	56 ± 7	58 ± 2	N.S.
Sex (% female)	49	67	0*	0*	25	<.05
Race (% Caucasian)	49	33	100*	100*	75	<.05
Duration (yrs) ($\bar{x} \pm$ s.d.)	11 ± 9	17 ± 10	7 ± 3	19 ± 15	19 ± 10	N.S.
Disease Activity (%)						
—Mild	45.7	66.7	0	33.3	25	N.S.
—Moderate-Severe	54.3	33.3	100	66.7	75	N.S.
Subcutaneous Nodules (%)	44	50	67	67	100	N.S.
Dyspnea (%)	6	17	0	33	0	N.S.
Pleuritis (%)	0	0	0	0	33	N.S.
Raynaud's Phenomenon (%)	17	0	67*	67*	33	<.05

**Significant at $P < 0.05$*

Table 3
Laboratory Profile of Patients with Rheumatoid Arthritis According to Type of Pleuropulmonary Pathology

Parameter	None	Pulmonary Fibrosis	Pleural Effusion	Pulmonary Nodule	OLD
ESR ($\bar{x} \pm$ s.d.)	36 ± 25	25 ± 36	44 ± 18	32 ± 29	52 ± 16
Rheumatoid Factor (%)	80	83	100	100	75
Rheumatoid Factor Titer (median)	1:160	1:320	1:320	1:80	1:80
Antinuclear antibody (%)	33	17	67	0	50
Hematocrit ($\bar{x} \pm$ s.d.)	40 ± 5	39 ± 3	40 ± 2	44 ± 1	38 ± 6
Albumin ($\bar{x} \pm$ s.d.)	3.5 ± 0.4	3.6 ± 0.7	3.3 ± 0.7	3.4 ± 0.8	3.1 ± 0.1
Alpha-1-antitrypsin ($\bar{x} \pm$ s.d.)	255 ± 71	299 ± 84	233 ± 99	266 ± 77	345 ± 169
Alpha-2-macroglobulin ($\bar{x} \pm$ s.d.)	209 ± 58	266 ± 83	173 ± 41	182 ± 19	229 ± 110
Fibrin Degradation Products (%)	50	40	66.7	50	66.7
Radiographic evidence of joint disease (%)	16	33	67*	0	75*

**Significant at $P < 0.05$*

patients, the β error is 10%.

Pulmonary Fibrosis

Although pulmonary fibrosis was five times more common in patients with rheumatoid arthritis (Table 1), insufficient subjects were present to be significant at P = 0.05 level. The observed 2:1 predominence of male involvement was identical to that noted by Stack and Grant.[9] Previous observations of lack of correlation of pulmonary fibrosis with disease activity,[1] pleuro-pulmonary symptoms,[1] presence of rheumatoid factor,[32] presence of subcutaneous nodules[2,15,33] or erosive joint disease[15] were confirmed in this study. Although the presence of antinuclear antibody has been suggested as a "prognosticator" for systemic disease in patients with RA,[34] it was not significant in the present study of pulmonary involvement.

Pleural Effusion

Although pleural effusion was three times more prevalent in patients with rheumatoid arthritis (Table 1), the present study did not demonstrate a statistically significant increase. The frequency of rheumatoid factor positivity approximated that previously reported.[15] Previous reports of male predominance[35-38] were confirmed. The present study documented a statistically significant association of erosive disease with presence of pleural effusion in patients with RA. This may reflect the observation of Brook, *et al.*[39] of a correlation between erosive changes and "eventually clinical outcome." The limited correlation of erosive disease to this form of rheumatoid pathology remains to be explained.

Pulmonary Nodules

Although pulmonary nodules were present in 6% of RA patients and absent in controls, insufficient subjects were present to be significant at P = 0.05 level. No association of pulmonary radiographic pathology with disease activity was demonstrated in this study. Previously reported correlations with presence of subcutaneous nodules[15,40,41] could not be confirmed. Raynaud's phenomenon was significantly more frequent among patients with pulmonary nodules. No evidence of Caplan's Syndrome[42-44] or pulmonary arteritis[45,46] was noted in the patients in this series.

Obstructive Lung Disease

Although pulmonary function tests have demonstrated that smokers with rheumatoid arthritis have a greater impairment of diffusing capacity than non-smokers,[15] no correlation of smoking with roentgenographic evidence of pleuropulmonary pathology was demonstrated in this study. The observation of a similar incidence of radiographic evidence of OLD in rheumatoid patients compared to controls has apparently not been previously noted.[9] Roentgenographic evidence of OLD, however, did not correlate with cigarette smoking in patients with RA. The flattening of the diaphragms and increased retrosternal air space noted in patients with RA may have a different pathophysiology than that noted in smokers and is a subject for further investigation. Its correlation with erosive disease perhaps indicates a more direct relationship to the "rheumatoid process."

Correlations

The presence of radiographic evidence of pleuropulmonary disease did not correlate with patient age, disease duration or activity, or symptoms of pleuropulmonary disease. Indicators of a less favorable prognosis[34,47,48] (subcutaneous nodules, rheumatoid factor, and antinuclear antibody) in joint disease progression did not correlate with pleuropulmonary findings. There was no evidence of any inhibitor protein abnormalities which could control pulmonary damage by elas-

Table 4
Factors Confounding Interpretation of Pleuropulmonary Disease

Parameter	Radiographic Finding: None	Pulmonary Fibrosis	Pleural Effusion	Pulmonary Nodule	OLD
Smoking (%)	32	50	33	0	0
Sjogren's Syndrome (%)	20	33	0	0	0
Therapy					
Salicylate (%)	57.1	83.3	66.7	33.3	75
>3gm/d (%)	31.4	33.3	33.3	33.3	50
Gold (%)	26	20	33	33	33

tase (alpha-1-antitrypsin)[49] or collagenase (alpha-2-macroglobulin).[25] Fibrin degradation products were present at low titers in all patients, but not significantly more so in those with pleuropulmonary pathology. While certain disorders (*e.g.*, Sjogren's Syndrome[50]) and drugs (*e.g.*, salicylates,[51,52] cyclophosphamide,[53] gold,[54-56] penicillamine,[57] methotrexate,[58-60] or cholorambucil[61]) may produce signs of pleuropulmonary pathology, there was no evidence of such a role in the present series.

The correlations of (a) erosive joint disease with pleural effusion and OLD and (b) Raynaud's phenomenon with pleural effusion and pulmonary nodules, should be further investigated. If pulmonary nodules and pleural effusion are considered manifestations of a vasculopathy,[15,36,62] it is perhaps not surprising that they are associated with another vasculopathy, Raynaud's phenomenon.[63] Since smoking did not correlate with the radiographic picture of OLD in RA patients, anatomic studies will be of interest to compare and contrast pulmonary pathologic findings in such patients to those noted in non-RA patients with radiologic evidence of OLD.

It is interesting to note that to detect a difference in prevalence of 5% with $\alpha < 0.05$ and a power $(1-\beta)$ of 0.8, 764 patients would have to be examined in both disease and control categories.[31] Achievement of a power of 0.9 would require 996 patients and a similar number of controls. Since β error reflects the risk of acceptance of the hypothesis when false, a β level of 10% or less is probably desirable.

This study has raised a number of questions, the evaluation of which will probably require a multicentre approach.

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References

A complete list of references for "Pleuropulmonary Radiographic Abnormalities in Rheumatoid Arthritis: Clinical, Epidemiologic and Laboratory Correlation," by Bruce M. Rothschild, M.D., *et al.*, may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

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Additional diagnositic information on page 100

Together We Can Make a Difference

"Shape Up" in Unity

By Betty Szewczyk, ISMSA Past President (1977-78)

"The patient comes first" is the first tenet of the AMA. This reason alone is enough to encourage support of the organization and participation in a group that subscribes to such a worthy philosophy in this day of change, shifting values and mercenary motivation. The AMA Auxiliary is the volunteer arm of the AMA and its members and potential members have a responsibility and a pride in promoting a doctrine that is of the utmost importance to every citizen in the US. . . a matter of life and death.

At no other time in history has it been more important that doctors, spouses, and all in the medical profession and field join together to preserve the high quality of care that the people of our country have available today. Government and outside interventions have brought about new procedures, and many more large changes are lurking in the shadows. None of these so-called practical and economic moves have anything to do with the quality of health care for the patient, but rather have everything to do with cost and cost containment.

Through AMA Auxiliary membership, physicians' spouses become a vital part of the health care world. It allows us to work together in a force of 80,000 auxilians to let Americans know that they have the finest health care in the world and that we in the medical family want to make sure they continue to have it. It is our common bond that enables us to pursue our common goal so effectively.

Through materials available from the AMA Auxiliary, members are provided with ideas and blueprints for developing programs. The strength of the AMAA lies in the federated structure that enables the national auxiliary to serve both as a clearinghouse and idea base for those at the state level who coordinate and those at the county level who implement.

There are three broad program emphases that are basic to meeting our common goal: health projects, fund raising for AMAERF, and legislative action. This year, "Shape Up For Life" (umbrella covering health care from cradle to grave) enveloped two timely health projects—prevention of child abuse and drunk driving. At the request of the AMA, which has renewed its efforts in child abuse prevention, the auxiliary is focusing on three areas: parenting education, public awareness, and helpful visitors in the homes of high risk families.

Drunk driving prevention efforts are directed to enacting and enforcing legislation to making the community aware of the magnitude of the problem, and to helping individuals learn what they can do.

While promoting these two programs this year (and looking forward to focusing in on "pre and post-natal" care next year), there are hundreds of health projects in which auxilians are involved to help their communities—screenings, health fairs, immunization programs, nutrition, and drug abuse prevention, to name a few.

Only well educated medical students will insure that the quality of health care in this country will remain at its present high level. For this reason, fund raising efforts for the AMA Education and Research Foundation are top priority as another way to reach our goal. Last year, $1.85 million was raised, and hopes are high that $2 million will be raised this year.

Legislative action is a vital program in these days when government at all levels is taking an increasing role in the way medical and health care is practiced. Auxilians must be both knowledgeable and involved in the health field, to be able to discuss medicine's viewpoint with the public, and also be in touch with legislators. Knowing the issues is most important. The national legislation committee has a slogan that says "Legislation: It's Up To You." And it is.

One of the most important aspects of belonging to the AMA Auxiliary is the sharing of a common bond, as well as a common goal. It is a wonderful experience to

attend a national meeting and talk with members from other states, sharing experiences and friendships that would not be possible without a federated organization.

Although in recent years, many of the programs have focused on community outreach, the importance of being able to share common concerns through the medical auxiliary has become very obvious. There is an increased emphasis in state and county auxiliaries on support groups, programs to help the families of impaired physicians, and seminars to strengthen the medical marriage and family. These are important programs and important experiences, for they cannot be found in any other organization.

AMAA provides materials to help members develop their skills and expand their knowledge: Professional Skills Development program, a service to document and record individual educational experiences to have easy access to a listing for personal or professional use; Project Bank and People Bank, a real networking of programs and people; Leadership Confluence, Annual Meeting of the House of Delegates, and National Cluster Meeting—all provide educational opportunity for personal development. In addition, materials are available from national headquarters, such as Package Programs and "how-to" manuals to enhance personal skills. The magazine FACETS (sent to every national auxiliary member) is directed solely to provide both personal and leadership information.

National committee newsletters help chairmen keep up with ideas and trends, and the Direct Line Newsletter informs state and county leaders in all of these areas. Cohesiveness and the ability to share ideas throughout the nation mean that the auxiliary can make a great impact on the health of the communities. This would not be possible without a federated structure.

The AMAA has a tradition of 60 years of community service, and the organization has changed and grown with the times. Now, facing a future of revolutionary change, unity and committment to goals are imperative. In recent years, consumer groups in many areas—environment, safety, government—have made a terrific impact. They have made that impact through unified action. Think of what can be done for our goal of quality living when a force of 80,000 knowledgeable, talented, caring physicians' spouses speak with one voice!

Questions or comments should be directed to Betty Szewczyk, North Central Regional Vice-President, AMAA, 17 Oak Knoll, Belleville, Illinois, 62223 ◂

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Hemispheric syndromes are reported as a consequence of neck flexion and rotation causing a compression of the internal carotid artery by the posterior belly of the digastric muscle and associated fascial bands. This was confirmed by angiographic studies. Complaints of positional symptoms of cerebrovascular insufficiency are not unusual. They are more common in the posterior circulatory system and are frequently missed on routine evaluations. The authors suggest angiography in positions that precipitate the symptoms. (Etheredge, S.N., *et al.: Arch Neurol* 41:672-3, June 1984)

The *Mayo Clinic Proceedings* reports that moxalactam is the antimicrobial of choice in patients with bacteremia who are neither neutropenic nor immunosuppressed. They feel it is a safe, effective and cost-effective alternative empiric antimicrobial in the absence of *Pseudomonas,* polymicrobial bacteremia, and extra-hepatic, intraabdominal sources of infection. (Wilson, W.R., *et al.: Mayo Clin Proc.* 59:318-26, May 1984)

Nine patients with angiographically confirmed obstructive arterial disease of the lower limbs were studied for prostacyclin activity. Prostacyclin, a potent vasodilator which inhibits platelet function, is the metabolite of arachidonic acid formed by the endothelial cells. Patients with arteriosclerotic vascular disease were found to have an increased urinary excretion of the metabolite of prostacyclin and enhanced platelet activation secondary to increased *in vivo* production of prostacyclin rather than an altered metabolism. This increased production of prostacyclin is in response to the local interaction of platelets with the endothelium and to other vascular insults. (FitzGerald, G.A., *et al.: N Engl J Med* 310:17,1065-8, April 26, 1984)

Paul Erne, M.D. and collaborators studied the intracellular level of free calcium in the platelets of 92 patients. The platelet calcium levels were significantly higher in patients with essential hypertension and these levels correlated well with the systolic, diastolic and mean blood pressures. Treatments with calcium blockers, beta-adrenoceptor blockers, or a diuretic resulted in comparable falls in blood pressures and calcium levels. The question of whether calcium elevation is the cause or the result of hypertension is not yet resolved. (Erne, P. *et al.: N Engl J Med* 310:17,1084-8, April 26, 1984)

The FDA Drug Bulletin states that oral contraceptives do not increase the risk of breast cancer, possibly protect against ovarian and endometrial cancers, but may increase the risk of cervical carcinoma. It also reports that urokinase and streptokinase have been approved for intracoronary use in lysing thrombi when used within six hours of symptom onset. The warning section of the professional labeling for the combination products of trimethoprim/sulfamethoxasole and erythromycin/sulfioxasole has been expanded. Death, severe reactions, toxic epidermal necrolysis, exfoliative dermatitis, hepatic necrosis,and blood dyscrasias warrant close monitoring of patients. (FDA Drug Bulletin 14:1, April 1984)

Blunt trauma to the chest with pulmonary contusion characterized by exudation of edematous fluid and blood into both alveoli and interstitial compartments of the lungs are maximally seen on Xrays within six hours of injury. Patchy mottled densities localized, scattered or coalesced and hemorrhage into interlobar septae or peribronchial spaces were asymptomatic in one third of cases. Resolution commences in 48-72 hours. Pulmonary infiltrates after 48 hours of injury may mean pneumonia or atelectasis. (Kabnick, E.M., *et al.: J Natl Med. Assoc* 76:4,413-14)

This study reports on the hypoxemia experienced by patients with chronic obstructive pulmonary disease during air travel in commercial airline flights. At 1650m the mean arterial Po2 decreased from 68.2mmHg to 51mmHg. Whether a patient will need supplemental oxygen to maintain arterial Po2 above a given value can be predicted from arterial blood samples taken while the patient is breathing a hypoxic gas mixture or room air within two hours of flight. (Schwartz, J.S. *et al.: Ann Intern Med.* 100:473-7, April 84)

Imipramine in patients with painful diabetic neuropathy was studied in a double blind, cross-over, placebo control method. The criteria were pain, paresthesia, dysesthesia, numbness and nocturnal aggravation. Seven of twelve patients reported notable improvement with close correlation of plasma level of imipramine and its metabolite desipramine to amelioration of symptoms. (Kvinesdal, B., *et al.: JAMA* 251:13,1727-30, April 1984)

Caffeine added to aspirin, phenacetin, acetaminophen and salicylamide appears to be an effective adjuvant for analgesia. This clinical study involved 10,000 patients over the last 20 years with pain from oral surgery, headache, episiotomy,and post-partum uterine cramping. To obtain the same effect without caffeine, approximately 40% more medication was required. (Laska, E.M., *et al.: JAMA* 251:13,1711-8 April 1984)

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510 Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

SEPTEMBER

Internal Medicine

Specialty Review in Hematology
For: Hematologists, Oncologists, Internists. Lecture, September 30-October 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $550. **Reg. Limit:** TBA. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Specialty Review in Nephrology
For: Nephrologists, Internists. Lecture, September 30-October 4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Innovations in Asthma Care
For: MDs. Workshop, September 29, 9am-3pm, Urbana, Illinois. **Sponsor:** Carle Foundation Hospital, Department of Medical Education, 611 West Park Street, Urbana 61801. **Fee** $35. **Reg. Limit:** None. **Credit:** Category 1, 5 hrs., AAFP Elective, 5 hrs. **Contact:** Deborah C. Rugg. **Phone:** 217-337-3022

Surgery

Fiberoptic Colonoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, September 19-21, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $490. **Reg. Limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, September 24-26, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $490. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Medical Practice

Second Annual Conference on Current Medical Events
For: MDs. Symposium, September 20-21, Springfield. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Infection Control

Advances in the Control of Nosocomial Infection—1984
For: MDs, RNs, Allied Health Professionals. Conference, September 20-21, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Use of New Antibiotics
For: MDs, Office Staff. Symposium, September 22, 1pm, Mt. Carmel, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield 62708. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711

Pediatrics

For: Pediatricians. Lecture, September 24-26, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $410. **Reg. Limit:** 90. **Credit:** Category 1, 24 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, September 24, 4:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, Departments of Medicine & Pathology, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

OCTOBER

Critical Care Medicine

Third Annual Critical Care Symposium
For: MDs. Lecture, October 11-14, 8am, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** University of Health Sciences/The Chicago Medical School, Department of Medicine, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $360/MDs, $240/Others. **Reg. Limit:** None. **Credit:** Category 1, 24.5 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Endocrinology and Metabolism

Recent Advances in the Diagnosis and Management of Endocrine Related Disorders
For: MDs. Seminar, October 11-12, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $200. **Reg. Limit:** TBA. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours; AOA, 14 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Pediatrics

New Perspectives in Pediatric Hematology/Oncology—Focus on the Practice Aspects of Diagnosis and Management
For: Pediatricians. Course, October 12-13, Chicago. **Sponsor:** The University of Illinois College of Medicine at Chicago, Department of Pediatrics, 912 S. Wood Street, Chicago 60612. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, 14 hours. **Contact:** Conferences and Institutes. **Phone:** 312-996-8025

Seminars in Pediatrics
For: Pediatricians and GPs. Seminar, October 12-13, Madison, WI. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $100. **Reg. Limit:** None. **Credit:** Category 1, 10 hours; AAFP, TBA; AOA, TBA; UW-Extension CEU's, 10. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Care of the Seriously Ill Child
For: MDs. Symposium, October 10-11, Indianapolis, Indiana. **Sponsor:** James Whitcomb Riley Hospital for Children & Indiana University Medical Center, Indianapolis, Indiana 46223. **Fee** $85.00. **Reg. Limit:** None **Credit:** Category 1, 10 hours. **Contact:** Jay L. Grosfeld, MD. **Phone:** 317-264-4681

Neurology

Diagnosis and Management of Strokes
For: Neurologists, MDs. Symposium, October 12-13, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin 53705. **Fee** $165.00. **Reg. Limit:** None **Credit:** Category 1, 11 hours. AAFP Prescribed, 11 hours. AOA, 10 hours. University of Wisconsin-Extension CEUs, 11 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Internal Medicine

Therapeutics 1984
For: MDs. Symposium, October 20, 8am-5pm, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, Wisconsin 53705. **Fee** TBA. **Reg. Limit:** None. **Credit:** Category 1, 6 hours. AAFP Prescribed, 6 hours. AOA, 6 hours. University of Wisconsin-Extension CEUs, 6 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

The 1984 ICCME Congress: "Technological Options in CME"

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American College of Physicians-Illinois Regional Meeting
For: MDs. Scientific Meeting, October 13-14, Urbana, Illinois. **Sponsor:** American College of Physicians, 1515 W. Walnut St., Jacksonville, Illinois 62650. **Fee** $85 Nonmembers, $75 ACP and ISIM Members. **Reg. Limit:** None **Credit:** Category 1, 9 hours. **Contact:** Frank Norbury, M.D. **Phone:** 217-243-6469

Radiology

4th Annual Breast Imaging Conference
For: Radiologists and Technologists. Lecture and Workshops, October 14-16, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, Wisconsin 53705. **Fee** TBA. **Reg. Limit:** None: **Credit:** Category 1, 18 hours. University of Wisconsin-Extension CEUs, 18 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Psychiatry

Comprehensive Psychiatry Review: Part II: The Psychiatric Interview
For: Psychiatrists. Course, October 25-27, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, Illinois 60637. **Fee** $375.00. **Reg. Limit:** None. **Credit:** Category 1, 17 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Health & Sports Science

LaCrosse Health and Sports Science Symposium
For: MDs, PTs, RNs, Nutritionists. Symposium, October 17-20, Civic Center, La Crosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program, 221 Mitchell Hall, University of Wisconsin, La Crosse. **Fee** $225 early, $250 regular. **Reg. Limit:** None. **Credit:** TBA. **Contact:** Philip K. Wilson. **Phone:** 608-785-8686

Cardiovascular Disease

Second Annual L. R. Nelson Cardiovascular Conference
For: MDs, CV Nurses and Technicians. Conference, October 13, Peoria. **Sponsor:** Methodist Medical Center of Illinois and the Methodist Medical Center Foundation, 221 N.E. Glen Oak, Peoria 61636. **Fee:** $15. **Reg. Limit:** 125. **Credit:** Category 1, 5 hours. **Contact:** Irving Favus, M.D. **Phone:** 309-672-5737

Surgery and Otolaryngology

Advances in Scar Revision and Camouflage
For: MDs. Seminar, October 15-17, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $350-$375. **Reg. Limit:** TBA. **Credit:** Category 1, 21.25 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Gynecology

Colposcopy and Clinical Management of Cervical Cancer
For: MDs. Lecture, October 26, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $100/MDs; $40/Others. **Reg. Limit:** None. **Credit:** Category 1, 8 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

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Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, October 29, 4:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

NOVEMBER

Internal Medicine

Advances in Internal Medicine
For: Internists. Lecture, November 12-16, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $500.00. **Reg. Limit:** 20. **Credit:** Category 1, 35 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Fiberoptic Esophagogastric Endoscopy
For: MDs. Lecture, November 12-14, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $490.00. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Flexible Fiberoptic Sigmoidoscopy
For: MDs. Lecture, November 17, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $145.00. **Reg. Limit:** 75. **Credit:** Category 1, 7 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Cardiology

Current Cardiology: Adults
For: MDs. Lecture, November 5-8, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee** $395.00. **Reg. Limit:** 90. **Credit:** TBA. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

2nd Annual L.R. Nelson Cardiovascular Conference
For: MDs, RNs, Techs. Conference, November 3, 9:30am-2:30pm, Peoria, Illinois. **Sponser:** Methodist Medical Center of Illinois and The Methodist Medical Center Foundation, 221 NE Glen Oak, Peoria, IL 61636. **Fee** $15.00. **Reg. Limit:** 100. **Credit:** Category 1, 5 hours. **Contact:** Irving Favis, MD. **Phone:** 309-672-5737

Current Cardiology: Children
For: MDs. Lecture, November 9-10, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $340.00. **Reg. Limit:** 90. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Cardiac Rehabilitation Workshop
For: MDs, RNs, PTs. Workshop, November 12-16, LaCrosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program Education Services Unit, Mitchell Hall, University of Wisconsin-LaCrosse, LaCrosse, Wisconsin 54601. **Fee** $450.00. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN=3.5 CEUs; Wisconsin Nurses Association, 35 hours; Iowa and Kansas PTs, 35 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** 608-785-8686

Infection Control

Advances in Control of Nosocomial Infection
For: MDs. Conference, November 15-16, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut, St., Madison, WI 53705. **Fee** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Geriatrics

Aging and Illness in Primary Care—4th Symposium On Ethical and Clinical Problems in the Care of the Elderly
For: MDs. Symposium, November 8-9, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee** TBA. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; University of WI-Extension CEU, 13 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Genetic Diseases

Genetic Determined Diseases
For: MDs. Symposium, November 10, 8am-12:30pm, Decatur, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

Medicine & Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, November 26, 4:30pm-6:30pm, North Chicago, Illinois. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, Illinois 60064. **Fee** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Allergy

Clinical Allergy for the Practicing Physician
For: MDs. Seminar, November 8-10, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: $250.00. **Reg. Limit:** 150. **Credit:** AAFP Prescribed, 19 hours; AMA Category 1, 19 hours; AOA, 18.5 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Stress Management

Anxiety and Depression
For: MDs. Symposium, November 29, 2:30pm-7:45pm, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

Teaching Stress Management and Relaxation Skills
For: MDs, RNs, PTs, OTs. Workshop, November 11-15, LaCrosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program Education Services Unit, University of Wisconsin-LaCrosse, Mitchell Hall, Room 221, LaCrosse, WI 54601. **Fee:** $450.00. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEUs; Nurses Assn, 35 hours; Iowa and Kansas, PT, 35 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** 608-785-8686

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MEDICAL DIRECTOR. Opportunity for physician with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; phone 608-251-4156.

FAMILY PRACTICE. Rapidly expanding staff model HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; 608-251-4156.

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FAR WESTERN SUBURBAN ILL. general practice available. Owner anxious to retire. Asking $85,000 for practice collecting $170,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093, (312)441-6111.

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SITUATIONS WANTED

POSITION WANTED—RADIOLOGIST seeking position full time, part time or locum tenens. Trained in diagnostic modalities. Write to Box #1096 c/o *Illinois Medical Journal*, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

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MARYVILLE PROFESSIONAL CENTER office space, Maryville, Illinois. ¼ mile from Oliver Anderson Hospital . . . within the "Growth Triangle" of Edwardsville, Troy, Collinsville, at Illinois 162 and 159, minutes from Interstate 55, 70, 270, 20 minutes from downtown St. Louis. Within 15 minutes of 175 residents having highest mean and median incomes, educational levels in Southwestern Illinois. Diversified plans for ownership or leasing. (618) 288-3388, or write Maryville Professional Center, PO Box 446, Maryville, Illinois 62062.

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EKG

(Continued from page 86)

Answers: 1. E 2. E.

The twelve lead ECG shows sinus rhythm with a PR interval of 0.26 seconds or first degree AV block. The QRS axis in the frontal plane is markedly rightward to −150°. There are tall R waves in leads AVR, V_1 and V_2 of 1.2 to 1.5 millivolts indicating a diagnosis of severe right ventricular hypertrophy. The T wave inversion present in leads V_1 to V_5 is probably a result of right ventricular hypertrophy. Tall P waves of 0.3 millivolts are present in lead II, suggesting right atrial enlargement. This ECG is certainly compatible with pulmonary hypertension. The physical examination suggests pulmonary hypertension as well as a diagnosis of ventricular septal defect. These two diagnoses suggest an Eisenmenger's physiology. Eisenmenger's complex consists of a ventricular septal defect, pulmonary vascular disease manifested by pulmonary hypertension, and right to left shunting of blood across the defect. This right to left shunt results in cyanosis, often a secondary polycythemia and clubbing of the fingers and toes. Surgical repair of the ventricular septal defect is contraindicated in patients with Eisenmenger's complex because the pulmonary vascular resistance persists and even worsens after surgical closure of the defect. Severe right ventricular failure can result. Although survival beyond age 50 years is unusual, these patients can often lead reasonably active lives. An increase in diuretic therapy in our patient improved his symptoms of dyspnea and easy fatigue. Periodic phlebotomies controlled the secondary polycythemia. ◀

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OB-GYN—PEDIATRICIAN TEAM

New Hospital Opening
In Fall of 1984
In Fulton, Missouri

This represents an outstanding medical practice opportunity. County of 30,000 primary service area with fine small community of 12,000+ hosting two nationally known colleges and a growing industrial base. We are close to the Lake of the Ozarks as well as multiple other recreational opportunities and facilities. The hospital has a fine tradition of strong family-practice physicians and has recently recruited an orthopedic surgeon to build its surgical team to two. There are over 400 births in this county each year, and the pediatric population is growing steadily. Residents want the best in specialist medical care. For further information regarding guarantees or other considerations contact Sharon R. Heinlen, Administrator, Callaway Community Hospital, Hospital Drive, Fulton, MO, 65251, 314-642-3376.

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ISMS Leadership Conference



Through the years, ISMS has sought to fulfill the needs and defend the interests of its members and their patients. Almost always, this has been accomplished through the regularly scheduled meetings of committees and councils, the Board of Trustees, and the House of Delegates. From time to time, ad hoc committees and task forces have been formed to address special and/or urgent situations.

In 1975, however, after the annual April meeting of the House of Delegates, two sub-acute problems facing the Society became acute—acute enough to cause the Board to call an unprecedented *special* meeting of the House of Delegates. The first was what became known as the malpractice crisis (of insurance cost and availability) of 1976; the second was the sharply deteriorating public aid (later to become Medicaid) situation. This meeting produced results. The Task Force on Professional Liability was formed, which spawned the Illinois State Medical Inter-Insurance Exchange; meaningful negotiations with public aid officials were productive.

Partly because this special meeting was so successful and partly because of other concerns, an *interim* meeting was called in 1976 and continued through 1982. In 1983, after considering the amount and quality of potential business for an interim meeting, the Board of Trustees wisely decided not to call one that year. Rather, it decided to address the contemporary problems of medical practice and called a *leadership conference* for all our members.

The leadership conference took place in Decatur last November. The theme was that today's member must not only be a clinician, but he or she must be a "legal expert, political organizer, communicator, economist, negotiator, and reviewer" as well. Experts in all these areas gave presentations, lectures, panels and informal discussions. The response was so positive that the Board of Trustees decided to have a second leadership conference this year. I can assure you that we will have an even better program, as we have built upon the strengths and have tried to eliminate the weaknesses of last year's program.

Please make every effort to join us in Rockford on November 10-11. You'll not be disappointed. ◀

Robert C. Hamilton, M.D.
President

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First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

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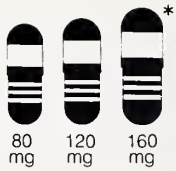
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INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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New York, N.Y. 10017

THE VIEWBOX

Contributing Editor Terrence C. Demos, M.D., Professor of Radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Cheryl Lindstrom, M.D., department of radiology, Loyola University Medical Center, Maywood.

This 52-year-old woman had a three month history of cough, fever, dyspnea, and night sweats. Figure 1 was taken on admission to the hospital. There was peripheral eosinophilia and an elevated sedimentation rate.



Figure 1. PA chest radiograph shows bilateral lung consolidation most pronounced in the periphery of the upper lobes.

Your diagnosis?

(1) Wegener's granulomatosis
(2) Loffler's syndrome
(3) Coccidiomycosis
(4) Chronic eosinophilic pneumonia
(5) Parasitic infection

(Continued on page 147)



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) *LONG ACTING CAPSULES*

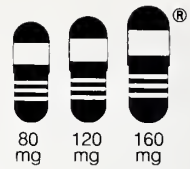


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JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
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CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

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INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

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Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

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Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

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If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

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Cost Awareness

One of the first steps necessary to attain the end of cost containment in medical care is cost awareness by those involved in providing that care. The issue of cost containment is one that is attracting increasing attention throughout not only our state, but the entire country. The president of the Illinois State Medical Society, Dr. Robert C. Hamilton, spends much of his time and effort, both as spokesman for the Society and as a private physician, in educating physicians and lay persons alike in this important subject. It is incumbent upon each of us as practitioners and members of ISMS, to continue and to strengthen this work, in each of our offices, hospitals, and communities.

In this month's issue of the *Journal*, one small aspect of cost awareness is discussed in an article entitled "Physician Cost-Awareness in the Prophylaxis and Treatment of Infection," by Jeffery D. Semel, M.D. In this article Dr. Semel has succinctly indicated how, by careful attention to the exact problems of the patient, we can adjust our antibiotic usage so that it is the most effective and least costly. We must quit the "drug of the week" mentality and be specific in our treatment and prophylaxis of infection. Dr. Semel shows us how we may be able to save anywhere from $200 to $300 a week by proper drug choice and usage.

As I indicated, this is just one small way to affect cost savings. What else might we do? How often have the surgeons among us had that one last cup of coffee in the doctor's lounge while the patient is lying anesthetized on the operating room table? The real cost of that 25¢ cup of coffee can be escalated by an increase of anywhere from $75 to $150 in unused operating room time, not to mention $25 to $100 in unused anesthesia time. Thus, just the simple step of promptness could save thousands of dollars each year.

Surgeons are not the only ones at occasional fault. Consider the medical patient who stays in the hospital two or three extra days or more in order to wait for the results of some laboratory test that could be easily interpreted after he or she was discharged.

Finally, we as physicians are not alone in our need to be educated and made aware of costs. The patient who insists on staying in the hospital an extra day after she has a baby so that she can get some rest, or the patient whose family cannot pick her up for two or three days after she is ready for discharge, often for relatively minor reasons, adds significantly to costs. And do not forget the patient who does not bother to call the physician for a minor problem but goes to the emergency room because "the insurance will pay for it."

These are just a few examples of ways we might help to slow down the rapidly accelerating costs of medical care. I am sure that each of you can think of several more examples and several more ways to effect savings in the care of both inpatients and outpatients. Perhaps if everyone would write the *Journal* with their suggestions, we would be able to provide a meaningful list which would help us all to begin thinking in more detail about how each of us can help. ◀

J. W. Roddick, Jr., M.D.
Chairman, Editorial Board

Scheduled October 10-11

ISMS Seminar to Address PPOs, Contracting for Physician Services

With competitive pressures giving rise to development of alternative health care delivery systems, the Illinois State Medical Society is sponsoring a seminar on Preferred Provider Organizations (PPOs) and contracting for physician services.

The three hour seminar will be held from 9a.m. to noon on Wednesday, October 10, at the Ramada Hotel, Rosemont, with a repeat session from 1:30 to 4:30 p.m. at the same hotel that day. On Thursday, October 11, the seminar will be presented from 1:30 to 4:30 p.m. at the Springfield Hilton Hotel in Springfield.

Attention has been focused on the PPO as a possible mechanism to preserve aspects of the fee-for-service system while introducing cost containment incentives associated with capitation systems. However, serious legal and political questions surround the movement toward PPOs in Illinois.

The ISMS seminar is designed to address some of the questions surrounding this issue:

- What is a PPO?
- How is it organized?
- How does it function?
- What are some of the socioeconomic, legal and quality of care ramifications of PPOs for physicians, hospitals and patients?
- What is the current status of Illinois law on PPOs, and is that status likely to change?

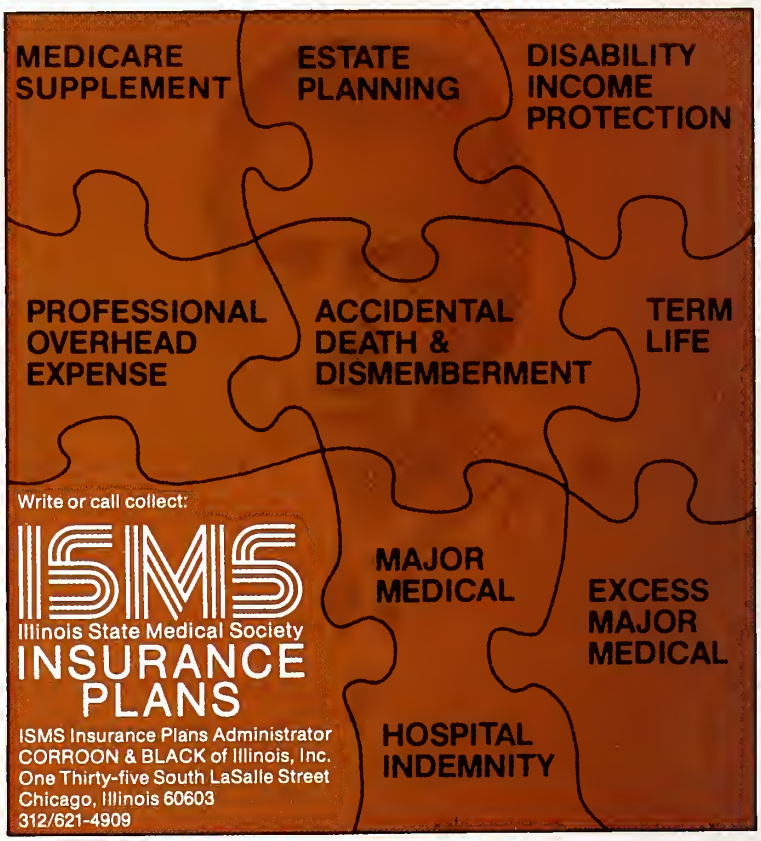
Registration materials for the seminar are being sent to all ISMS members. The seminar is free of charge to members of ISMS, the ISMS Auxiliary and the Illinois Medical Group Management Association. Non-members may attend for a fee of $25. ◂

SOLVE YOUR PROTECTION PUZZLE

The insurance puzzle... are there pieces missing from your picture?

As a member of ISMS, you can realize substantial benefits by participating in society-approved insurance plans. Designed and administered by professionals in cooperation with ISMS, this program could be the answer to your personal and professional needs. While your requirements receive individual attention, you also enjoy the economies of ISMS group purchasing power.

COMPLETE PROGRAM PROFILE OFFERED WITHOUT OBLIGATION



How to become an expert on low back pain in one luxurious weekend.





When you come to our seminar on **The Conservative Management of Low Back Pain,** you'll learn about the latest developments in everything from workup protocols and osteoporosis to decision making and the cost effectiveness of care.

If you're a primary care physician, you won't want to miss this informative seminar, October 19-20, 1984, presented by the Institute for Low Back Care and Camp International, Inc., and sponsored by Abbott Northwestern Hospital and its rehabilitation division, Sister Kenny Institute.

The seminar will be held at the new Amfac Hotel in the Minneapolis City Center—the largest convention hotel and urban shopping complex in the Upper Midwest. Which means you'll have a host of exciting extracurricular activities that should make your weekend a luxurious holiday.

For more information about this valuable educational seminar, contact Isabelle Green, R.N. at (517) 787-1600 extension 291.

Focus on Professional Liability, Alternative Delivery Systems

ISMS Leadership Conference November 10-11

The Illinois State Medical Society's initiative for professional liability reform, the move toward contracting for physician services, and other alternative health care delivery systems will be the focus of ISMS' Leadership Conference.

The Leadership Conference is scheduled for November 10-11 at the Clock Tower Inn, Rockford. It will be open to all ISMS members.

Malpractice Reform

Primary emphasis will be placed on an initiative for professional liability reform that is being conducted by the ISMS, with the assistance of the Illinois State Medical Inter-Insurance Exchange. A conference overview on Saturday morning will highlight the Society's effort to encourage the General Assembly to pass legislative reforms that would restore some balance to the system for handling medical malpractice complaints. Another Saturday session will present a panel discussion by members of the General Assembly, who will examine the legislature's receptiveness to malpractice reform.

Illinois physicians are being faced with a "crisis of affordability' in premiums for liability insurance. That crisis has been prompted by skyrocketing damage awards by juries and the proliferation of nonmeritorious suits.

An integral part of the leadership conference program on the professional liability initiative will be devoted to organizing local efforts to achieve legislative reform. Sessions will discuss organizing a grass roots lobbying effort at the hospital medical staff and county medical society level. Organizing physician/legislator networks through the ISMS Key Contact program, the ISMIE Network Representatives, and the participation of the ISMS Auxiliary also will be addressed.

In addition, training sessions will be held to help physicians polish their interpersonal skills for speaking before public forums and interviews with members of the news media. Other instructional sessions will consider how to influence legislators, how to discuss the professional liability situation with patients, and how to enlist support from physicians' personal legal counsel.

Alternative Delivery Systems

As competitive pressures from the changing health care marketplace continue to increase, a portion of the Leadership Conference will focus on the development of mechanisms to contract for physician and hospital services. Contracting and other delivery alternatives are being pursued by business and third party payors anxious to check the rise in the cost of health care benefits.

One contracting alternative to be discussed will be the Preferred Provider Organization (PPO). PPOs have been touted as one way of preserving some aspects of the fee-for-service system while introducing the cost containment incentives sometimes associated with capitation systems. However, serious legal and political questions surround the movement toward PPOs in Illinois.

The registration fee for the two-day Leadership Conference is $40 for ISMS members or their spouses who wish to attend all sessions. Spouses who wish to attend only meal functions may do so for a fee of $20. The fee for physicians who are not members of ISMS is $100.

Registation information will be sent to all Society members. Additional information is available from ISMS, 55 East Monroe, Suite 3510, Chicago, IL 60603 (312) 782-1654. ◀



ISMS LEADERSHIP CONFERENCE

LEARN WHAT THE ILLINOIS STATE MEDICAL SOCIETY IS DOING TO PROMOTE PROFESSIONAL LIABILITY REFORM IN ILLINOIS... AND WHAT YOU CAN DO TO AID THE ISMS EFFORT

The November 10-11 Leadership Conference is designed to explain the elements of the professional liability initiative which ISMS has undertaken.

Sessions during the Leadership Conference will:

- Examine the legislative proposals offered by ISMS to restore balance to the system
- Explain the lobbying activity that will be necessary to obtain passage of remedial legislation
- Outline efforts to enlist support of the news media and the general public
- Help physicians polish their interpersonal skills for speaking engagements before public forums and interviews with members of the news media
- Instruct physicians on how to organize local efforts to influence legislators, discuss the professional liability situation with patients, and enlist the support of their personal legal counsel.

Also featured will be a look at alternative health care delivery systems which have flourished as the result of pressures for cost containment. HMOs, IPAs, and the new Preferred Provider Organizations (PPOs) will be the focus of discussions at other sessions during the two day conference.

November 10-11, 1984
Clock Tower Inn/Rockford, Illinois

Attendance at the ISMS Leadership Conference is open to all ISMS members, who will receive formal notice and registration material by mail.

Additional information is available from ISMS, 55 E. Monroe, Suite 3510, Chicago, IL 60603 (312) 782-1654.

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DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

The 1984-85 officers of the Chicago Medical Society are **Jere E. Freidheim, M.D.,** Burr Ridge, president; **Harold L. Jensen, M.D.,** Flossmoor, president-elect; **Robert M. Vanecko, M.D.,** Chicago, secretary; **James H. Andersen, M.D.,** OakBrook, chairman of the council; **Ulrich F. Danckers, M.D.,** River Forest, vice chairman of the council and **Joseph C. Sherrick, M.D.,** Northbrook, treasurer.

Tien C. Cheng, M.D., has been named a member of the American College of Cardiology. . . . **Leo P.A. Sweeney, M.D.,** Evergreen Park, has been elected secretary-treasurer of the Fifty Year Club of American Medicine. Dr. Sweeney is an ISMS past president.

MEDICAL-LEGAL CONFERENCE ANNOUNCED

The American College of Legal Medicine will sponsor a conference in conjunction with the annual meeting of the Association of American Medical Colleges, October 31-November 1, 1984, at the Conrad Hilton Hotel in Chicago. "The Growing Role of the Law in the Practice of Medicine," will be the theme for the meeting, chaired by Donal D. O'Sullivan M.D., J.D. and featuring a number of Illinois physicians.

Topics on the first day will include legal aspects of perinatal care, the relationship of the hospital and its medical staff, physician contracting, marketing a medical practice, financing and managing a medical practice, general insurance information and estate management. On Thursday, November 1, the program will concentrate on legal and ethical concerns involving care of the terminally ill, criminal law, negotiation and arbitration, quality assurance and antitrust considerations. The program has been approved for 12 hours' category 1 credit applicable toward the AMA Physician's Recognition Award. Cost is $125 by check payable to the American College of Legal Medicine, 213 W. Institute Place, Suite 412, Chicago 60610. Registration forms may be obtained by contacting the College at 312-440-0080.

PATIENT EDUCATION IN KIDNEY DIALYSIS

The National Kidney Foundation has published a new brochure, "Nutritional Considerations for the Patient Before the Initiation of Dialysis." It is available to physicians who seek to educate their renal disease patients. Ordering information may be obtained by writing the National Kidney Foundation, 2 Park Avenue, New York NY 10016.

HELPING HYPERTENSIVE PATIENTS STOP SMOKING

A new publication, "The Physician's Guide: How to Help Your Hypertensive Patients Stop Smoking," is available at no cost to ISMS members from the ISMS Division of Medical Services. The booklet, developed by the National High Blood Pressure Education Program, gives advice on how to approach patients about their smoking problem, and how to set up a program to reduce and end smoking.

Iatrogenic Impairment?

Depression, substance abuse, and suicide are all known to occur to physicians at rates exceeding those for the general public. In fact, some researchers estimate that 5-10% of all physicians have problems with drugs, alcohol, or mental or physical disabilities severe enough to interfere with their ability to practice. When the term "impairment" is used to denote these occupational hazards of medicine, it is often met with blank looks from medical students, rather than awareness and recognition. This is unfortunate, for current studies show that medical education is a fertile ground where the seeds of such impairment may be sown.

Most students enter medical school filled with idealism and well defined expectations of their education and the way in which they will meet its demands. For some, idealism becomes disillusionment, as they discover that there is never enough time, energy, or memory capacity to keep up with the material which must be learned. Curriculum hypertrophy tends to convert learning into a process of reciting facts but ignoring their theoretical basis while exams seem to reward parrots and not problem-solvers.

In the clinical years the pressures of time promote chronic frustration: laboring under requirements that seem needlessly harsh, students adopt a schedule which designates eating, sleeping, exercising, personal and family needs as low priority activities. The feeling commonly arises that missing meals shows fortitude. Since students are encouraged to feel that they need to prove their dedication, few would dare suggest taking a break for a luxury like lunch. The message here is that the measure of a physician is in the ability to inflict upon oneself wholly unnecessary acts of self-denial. Medical training then becomes perceived as an initiation rite, a uniquely trying ordeal sanctifying the path to physicianhood. And at every step the student hears that the pressure will only get worse.

Further down this path, cynicism replaces mere disillusionment, as students often find insufficient understanding or support from those who would serve as role models. Some physicians seem to feel that stress is a magic potion which teaches discipline, strength, and sacrifice, forcing students to flourish under pressure. According to this view, functioning on the edge of exhaustion teaches students and residents how to make decisions in the worst of possible circumstances. And by providing schedules which permit little rest, circumstances are kept always at their worst. In this setting sleep deprivation becomes yet another dedication—proving task. Never mind that it promotes depression, irritability, memory deficits and difficulty in thinking. Crucial decisions are therefore made automatically, reflexively, and without the benefit of thought.

In response to these stresses, the student and resident adopt survival techniques which seem justifiable despite their effect on health, social and family relationships, and self-esteem. Passive acceptance of traumatic events leads the individual to believe that such trauma is inevitable. As a result, even when escape is possible, none is attempted. Lack of sleep, exercise, and poor nutrition, which at first may have been considered only temporary phenomena, may become a way of life. Almost without knowing it, the new physician may initiate behaviors that can end in serious impairment of the

capacity to practice medicine.

Even if students become aware of any incipient problems, they may be reluctant to seek help from a school mental health system which may lack confidentiality. They may be unwilling to contradict professors who insist that years of experience have conclusively demonstrated the value of such harsh training rites. The students may not realize that their mentors' claim to objectivity is rendered meaningless by both the passage of time and by the psychological effects of the initiation process itself, a process which promotes an inflated and rationalized estimate of its ultimate value in direct proportion to the severity of its challenges.

As each succeeding generation of physicians adopts the attitude, "If I did it, so can you," the stressful parts of medical training which may be precursors of impairment persist as essential elements in the rites of passage, unlikely to ease without basic changes in the educational philosophies of medical schools and residency programs.

While the preceding discussion may make the outlook appear bleak, the conditions which promote iatrogenic impairment are not engraved in stone. Change is indeed possible. The contribution to physician impairment made by the stresses of medical training has recently attracted attention in the literature and several groups have begun to focus on strategies to improve the situation. There are attitudes which students and residents might adopt, and some actions which might be taken, to improve the future outlook. By understanding how stresses develop, learning to detect maladaptive behaviors, communicating their concerns to school officials, and guarding their own health as diligently as that of their patients, students and residents might work together with their spouses and the faculty to increase their chances of surviving the hazards of medical training.

To this end, a conference entitled "The Hazards of Medical School and the Potential for Impairment" will be held on September 29, at the University of Illinois School of Medicine at Chicago for medical students, school officials, counsellors, faculty, and other interested persons. This meeting is sponsored jointly by the ISMS Committee for the Impaired Physician, the ISMS-MSS, the American Medical Society on Alcoholism, the Illinois Council on Continuing Medical Education, and the University of Illinois School of Medicine at Chicago. Persons interested in attending should contact ISMS, Division of Medical Services, 55 East Monroe, Suite 3510, Chicago, Illinois 60603, (312) 782-1654. ◀

Tom Zusag
U of I '86



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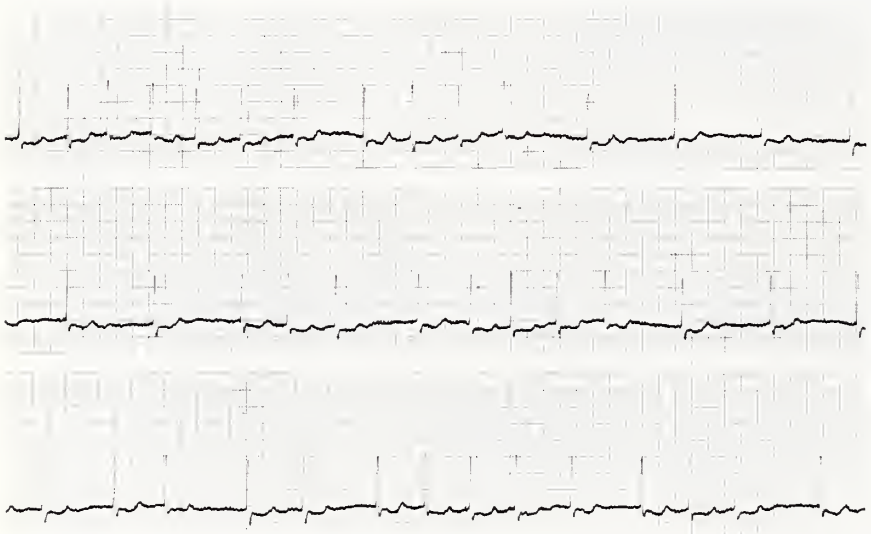
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

The patient is a seventy-nine year old lady who was referred for an evaluation of an eight pound weight loss, a change in bowel habits, and some bright red blood from the rectum. She had no current cardiac complaints. However, seven years earlier, she had complained of marked dyspnea on exertion and peripheral edema. She had also had a two pillow orthopnea and intermittent palpitations at that time.

Her physical exam seven years ago had demonstrated rales in the lungs with right lung base dullness, atrial fibrillation, cardiomegaly and severe mitral regurgitation. A coronary angiogram was normal. Management of her congestive heart failure resulted in a 30 pound weight loss. Subsequently, open heart surgery was performed with a mitral valve replacement. She remained asymptomatic until the above bowel complaint started. Sigmoidoscopy to 15cm revealed an irregular polypoid lesion which was biopsied. The biopsy showed adenocarcinoma of the colon. She was admitted to the hospital and ECG telemetry showed this cardiac rhythm.



Questions:

1. The ECG rhythm strip shows:
 a. Complete atrioventricular (AV) block.
 b. Atrial fibrillation.
 c. Non-specific or non-diagnostic ST-T wave changes.
 d. Junctional escape beats.
 e. All of the above.

2. The following statement(s) is/are true:
 a. This patient requires a temporary ventricular demand pacemaker.
 b. The presence of a mitral valve prosthesis precludes all consideration of general surgery.
 c. This cardiac rhythm suggests digitalis intoxication.
 d. This cardiac rhythm means there is metastatic adenocarcinoma to the pericardium.
 e. None of the above.

(Continued on page 180)

Viewbox

(Continued from page 131)

Diagnosis: Chronic Eosinophilic Pneumonia



Figure 2. Peripheral areas of consolidation in Figure 1 have almost completely resolved after two weeks of corticosteroid therapy. The patient was asymptomatic at this time.

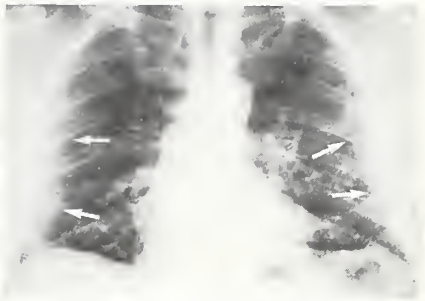


Figure 3. A second patient with bilateral peripheral lung consolidation (arrows) due to chronic eosinophilic pneumonia.

All of the choices given can cause parenchymal lung disease associated with blood or tissue eosinophilia. The causes of pulmonary infiltrates with eosinophilia (PIE) are numerous. They include drugs, infections and collagen diseases (Table 1).[1,2] Idiopathic transitory, migratory pulmonary infiltrates which clear without treatment are well known as the Loffler syndrome.

Since only one radiograph (Figure 1) was shown, progress of the lung involvement cannot be evaluated. Location of the lung consolidation in the patient presented, however, is peripheral with sparing of the perihilar zones. This pattern has been called the "photographic negative of pulmonary edema" and is characteristic of chronic eosinophilic pneumonia.[3] The patient's symptoms resolved within days of corticosteroid therapy and the lung lesions almost completely cleared after two weeks (Figure 2). The patient was taken off steroids six months after initiation of treatment and there was recurrence of the same symptoms and infiltrates in the same unusual peripheral location, which again responded to steroid therapy. This completes the triad which is virtually diagnostic for chronic eosinophilic pneumonia:[4]

- Infiltrates arranged in a peculiar peripheral pattern with segmental or lobar distribution.
- Rapid resolution of infiltrates with corticosteroid medication.
- Recurrence of the infiltrates in the same unusual peripheral location during relapse.

Table 1
Pulmonary Infiltrates with Eosinophilia

Idiopathic:	Loffler's Syndrome	
	Chronic Eosinophilic Pneumonia	
	Hypereosinophilic Syndrome	
Drugs:	Chlorpropamide	Hydralazine
	Penicillin	P-Aminosalicylic acid
	Sulfonamides	Hydrochlorothiazide
	Mephenesin	Cromalyn sodium
	Mecamylamine	Nitrofurantoin
	Clofiberate	Tolazamide
Parasites:	Ascariasis	Ancylostoma
	Strongyloides	Toxocara canis
	Hookworm	
	Shistosomiasis	
	Pulmonary larva migrans	
Collage Vascular Diseases:	Wegener's granulomatosis	
	Allergic granulomatosis (Churg-Strauss Syndrome)	
	Lymphomatoid granulomatosis	
	Polyarteritis nodosa	
Infections:	Brucellosis	
	Aspergillosis	
	Coccidiomycosis	
Rare:	Childbirth	Lymphography
	Smoke inhalation	Nickel hypersensitivity
	Blood transfusion	

Clinical

As indicated by Table 1, there are many known causes of pulmonary infiltrates with eosinophilia,[5-9] but the etiology of chronic eosinophilic pneumonia remains unknown. Peak incidence is in the fifth decade,[10] but no age group is exempt and chronic eosinophilic pneumonia has even been reported in a one year old child.[11] Females predominate by two to one. An association with asthma has been noted,[1,10] but the asthma was always of relatively recent onset and asthmatic symptoms tended to persist after corticosteroid treatment.[4] Other associations include a family history of asthma,[4] penicillin allergy,[4,12] tetracycline allergy,[4] allergic rhinitis or nasal polyps,[1] as well as rheumatoid arthritis[13,14] and ulcerative colitis.[15]

Patients with chronic eosinophil-



Figure 4. Typical dense peripheral consolidation (arrows) in a third patient with chronic eosinophilic pneumonia.

ic pneumonia may present with fever, cough, dyspnea, weight loss and night sweats. Quite often the illness is protracted, and patients have been treated for bacterial pneumonia or tuberculosis without improvement.

Laboratory

There is often peripheral eosinophilia and an elevated sedimentation rate, but in one study, ⅓ of patients did not have peripheral eosinophilia.[1] Thrombocytosis up to 900,000mm^3 has been found in early stages.[16]

Radiology

The admitting chest radiograph reveals the photographic negative of pulmonary edema in 65-76% of cases (Figures 1, 3).[1,10] Biopsy proven cases have been reported, however, where chest radiographs remained normal throughout the course of the disease.[17] Pleural effusion is rare.[1,18] Computed tomography in a patient with typical symptomatology showed mediastinal lymphadenopathy and peculiar, vertically oriented plate-like infiltrates.[19]

The natural history of the disease is well established. Permanent spontaneous remission is seen in less than 10% of patients.[10] Following the institution of corticosteroid therapy, symptoms usually resolve within 48-72 hours and the chest radiograph returns to normal within 1-3 weeks.[1-10] When steroid therapy is withdrawn, ⅓ of patients relapse with recurrence of the same symptoms and infiltrates in the same location.[4,10] Relapse appears to be preventable by maintaining low dose steroid therapy.

Pathology

Transbronchial or open lung biopsy have been used to obtain tissue for diagnosis. Histologic findings include flooding of the small air spaces by eosinophils and macrophages and a mild interstitial pneumonia. Bronchiolitis obliterans occurs in a minority.[1] Electron microscopy has shown eosinophils and macrophages in the alveolar space and interstitial tissue. Deposits of immune complexes have not been seen.[10]

Pulmonary Function

Lung function studies during the acute phase of the illness show severe restrictive and gas transfer defects, the latter more severe than can be accounted for solely by reduction of alveolar volume. Gas transfer defects are eliminated following therapy and fixed volume restriction is unusual except in those patients with a severe protracted course before treatment or with repeated recurrences after steroid withdrawal. The process does not appear to be entirely reversible as tests of small airway function remain abnormal.[10] This finding is in keeping with the pathologic finding of bronchiolitis obliterans in ⅓ of patients.[1]

Patients with typical clinical, roentgenographic and laboratory findings may be treated with corticosteroids without obtaining further diagnostic studies.[20] Lung biopsies may be necessary if there is no peripheral blood eosinophilia or the chest radiograph is not characteristic. In this latter group of patients further experience with techniques such as bronchoalveolar lavage (BAL) or technitium-99^m glucoheptonate (Tc-GHA) scanning may allow diagnosis without open lung biopsy. A recent study comparing BAL, Tc-GHA scanning and transbronchial lung biopsy suggested that bronchoalveolar lavage, with transbronchial lung biopsy, is a satisfactory method of diagnosing chronic eosinophilic pneumonia if the classic findings are not present.[20] ◀

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Two Illinois Physicians Enter November Election Races

Many times physicians say that it is too bad that there aren't more physicians running for political office. Two prominent Illinois physicians have decided to do something about the situation.

Dr. Herb Sohn and Dr. Robert Hamilton are running for the U.S. House of Representatives and the University of Illinois Board of Trustees, respectively. Both have long been active in the affairs of the Illinois State Medical Society. And both felt an obligation to run as a citizen and as a physician.

"As a physician," Dr. Sohn said recently, "especially as a surgeon, I face hard problems every day. I don't run away from them. I was very disappointed in this last congress because it adjourned with a $200 billion deficit. I think that was obscene. I would not do that." Dr. Sohn is presently chairman of the ISMS Public Affairs Committee and a member of the ISMS Governmental Affairs Council.

ISMS President Hamilton said that he was surprised to hear that, if elected, Dr. Sohn would be one of only two physicians in the House of Representatives. As a physician, Dr. Hamilton will be similarly in the minority on the University of Illinois Board of Trustees if elected.

In addition to his duties at ISMS, Dr. Hamilton was recently named to a blue ribbon task force that is investigating the Cook County Coroner's Office. He was named to this task force by the attorney general. He was also at the side of Governor Thompson when the hospital cost bill was signed into law. ◀

Report on National Meeting

The June 15-16th tenth anniversary meeting of the AMA Resident Physicians Section marked a turning point in its maturity as the national voice of residents. The election of Dr. Ronald Davis to the resident seat of the AMA Board of Trustees, combined with 15 ISMS Resident Physicians Section delegates and alternates now serving the AMA House, reinforced our leadership role in the organization.

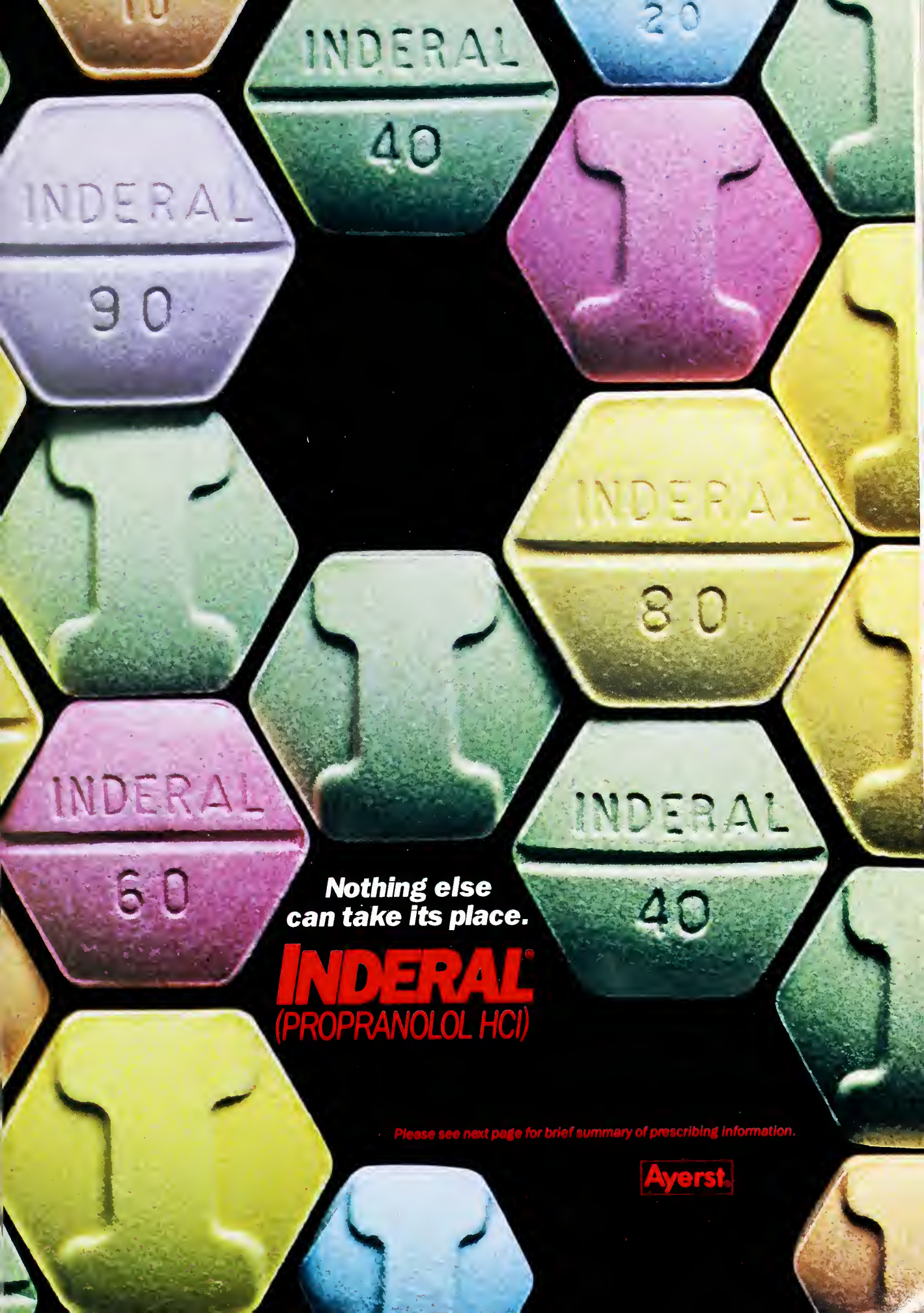
Now 29,000 members strong, with a record 121 residents in attendance at the meeting, the AMA-RPS turned from years of organizational growing pains toward devoting its talents wholly to serious socioeconomic issues that bear directly on how our generation will practice medicine in coming years. Residents heard workshop presentations on teaching methods, computers-in-medicine, and "Keeping the Momentum" in state RPS' during the 2.5 day meeting. In addition, five AMA-RPS task forces are to be formed to study (1) overall environment of a resident; (2) medical education; (3) long-range planning and development; (4) legislative matters and (5) organizational development of the RPS. Twenty resolutions and eleven reports reflecting the contemporary concerns of resident physicians were considered by the AMA-RPS. Five of these were introduced by Illinois residents. These dealt with: the safety and efficacy of nicotine chewing gum as an aid in smoking cessation (a resolution that was transmitted to and adopted for study by the AMA-House of Delegates); the application of tax stipend deductions reflecting the educational purpose of residencies; downward trends in resident salaries versus inflation and internal procedural AMA-RPS election and credentialing matters.

Additional AMA-RPS resolutions that were adopted and received favorably by the AMA House of Delegates included (1) a request for the AMA to support the concept of open medical staffs and to conduct a survey by state to determine what proportion of medical staffs conform to this policy and to that of the AMA Judicial Council on medical staff privileges; (2) encouragement by the AMA of a non-governmental body to critically review the Veterans Administration health delivery system and (3) asking the AMA to support non-smokers' rights aboard aircraft. Other AMA-RPS resolutions whose intents were preserved included a "filed" report on trends in prenatal and infant care with an urging to restore funds for care of indigent women and their infants; and a "referred" resolution asking the AMA to recognize trauma as an alcohol-related condition and to recommend designation of taxes from alcohol sales for prevention of alcohol abuse.

From my vantage-point as a national delegate to the resident and student sections for the past four years, much indeed has been accomplished by the AMA-RPS as the national voice of the resident perspective. Residents of Illinois can take pride in our ISMS-RPS' strong contributions toward making that voice heard. ◀

Charles Cattano, M.D.

The next meeting of the RPS Governing Council will be at 6:30 p.m. October 11 at ISMS headquarters.


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10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects, angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL. In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC. Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing, at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetics).

PHARMACOKINETIC. A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml•hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL (propranolol hydrochloride) should be administered with caution since it may bloc bronchodilation produced by endogenous and exogenous catecholamine stimulation of bet receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability c the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty i starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal ma lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in anim studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal o therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypoten sion, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with achin and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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Communicate
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Thoughts on Being Widowed

By Jane K. Klaren, chairman, ISMSA Committee for Widows and Spouses of Retired Physicians and ISMSA Past President

When I repeated my wedding vows many years ago, I might have given pause to the word "obey," (being of a rather independent nature) but I am certain I did not give a second thought to the "till death do us part." Death was such a remote possibility when I was 21. When it did occur, it turned out to be the single most painful experience of my existence.

Widowhood is probably life's most awkward stage, whether at 39 or 90. There was a point when I decided that the Indian practice of widows jumping on the funeral pyre (probably before they were pushed) made eminently good sense. It solved so many problems. Widows can be such a nuisance and an embarrassment at times—even to themselves. What does one do with them? I never quite knew in the past.

That nebulous state is especially traumatic today, when many of the young who traditionally gave support to the elderly, infirm, widows and orphans have not always sorted out their own lives. Rapid changes in social mores have left them adrift. There seem to be so many emotional, social and financial problems to be resolved before they feel able to go beyond themselves. Their path is unclear. Traditional structures are no longer holding up for them. Government and legislative policies concerning family and home are thinning, so the widow must often find her own way.

The dichotomous life led by doctor's spouses helps prepare them for widowhood in one way, and makes them vulnerable to it in another. On the one hand, the authoritarian personality of many physicians, resulting from the daily assumption of responsibilities faced by few others in our society, can hamper growth in their partners. On the other hand, the same life can make their wives capable of running the establishment single-handedly after years of smoothing the path to create a serene environment for their weary mates. They have had to do many things on their own, so this is not new to them.

Life moves so fast that there often doesn't seem to be a place for the widows who opted for home and hearth and all that that entailed in the 40's. Their traditional contributions are not necessarily even valued today. Those of us in that age category sometimes look back and wonder how we can justify our lives by today's standards. Of course, we know within ourselves that we had the best of both worlds and that we used our time and talents to the best of our ability. But we do get an unsettled feeling when it is scrutinized and measured by today's social yardstick. It will be some years before today's great balancing act of home, family and "career" can be accurately evaluated, but as widows of older professional men, we have already experienced an acute identity crisis, without having the worth of our past performance negated by newer standards.

Financial and legal problems also have to be worked through. The patient's perception is that the "wealthy doctor's widow" does not need the money owed the doctor and, besides, the doctor is dead, so it really isn't owed anymore. Some patients get indignant when pressed—especially if the doctor was "understanding" (another word for soft-touch). There is little one can do about the situation when grieving and vulnerable if not informed beforehand. It is an impossible time to start learning the realities of terminating a medical practice. Before coming to this

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Breast Cancer Following Radiation Exposure

By Larry C. Gunn, M.D./Hinsdale

A 36-year-old woman who had received 2700 rads of thoracic radiation for asthma between the ages of 17 and 21 underwent a left breast biopsy for a mammographically discovered abnormality which proved to be a multifocal intraductal carcinoma in situ. *Bilateral total mastectomy revealed lobular carcinoma* in situ *of the left breast and a focal infiltrating ductal carcinoma of the right breast, a lesion not noted on either physical or radiographic examination. The evidence supporting an increased incidence of breast carcinoma in women exposed to radiation is presented.*

Since the increased risk of developing breast cancer begins at an exposure level of only 75-100 rads, diagnostic and therapeutic Xray should be used judiciously. This is especially true in younger women who are even more susceptible to the carcinogenic effects of ionizing radiation.

Once identified, this subgroup of women at high risk for the development of breast carcinoma must be carefully followed.

Exposure to ionizing radiation has long been known to increase the likelihood of several types of malignancy and is well documented.[1-8]

This case report details an instance in which bilateral breast carcinoma arose fifteen years following Xray therapy for asthma.

Case Report

A 36-year-old nulliparous white female with a history of mastodynia, a normal 1967 mammogram, and a family history negative for breast carcinoma was evaluated for nodular breasts. She had a normal menstrual history and had no nipple discharge. The patient was not taking estrogens or oral contraceptives. She had been treated with steroids for asthma since the age of 18. Between the ages of 18 and 21, she had received Xray therapy for asthma, employing a 200KV machine at 1.5M.A. Previous screening for thyroid carcinoma was negative, after which she had been placed on 0.2 mg. of levothyroxine sodium daily.

The allergist who provided the treatment states that he and his partner began radiation treatment for asthma in the 1930's. He states that they have never had any problems with radiation therapy and that it was his impression that there was a lower incidence of lung and breast cancer in patients radiated for asthma than in the general population. He did not comment on what degree of success had been experienced utilizing external beam radiation therapy for asthma. The initial physician stated that a review of the records showed that she was given a total of 4,500 rads in radiation treatment. He states that 1,800 rads were given to the sinus only and were carefully coned to treat only the sinuses. He states that 1,100 rads were given to the posterior chest and that, in the opinion of the attending radiologist, almost all of the radiation would have been absorbed by "chest and lung tissue." 1,600 rads were given to the anterior chest. He states that this dosage was coned so that the treatment was primarily to the mediastinal and central bronchial area.

Physical examination revealed diffuse shotty nodularity of both breasts with no dominant masses and no skin or nipple changes. Two 1cm nodes were palpable in the left axilla.

Xeromammography revealed a 2cm area of fine calcific stippling in the medial left breast. Using injection mammography for localization,[9] a left breast biopsy was performed and specimen mammogra-

phy obtained. Microscopic examination confirmed the presence of multifocal noninfiltrating intraductal carcinoma.

The patient was admitted to the hospital for definitive treatment. A bone scan was within normal limits. Chest X-ray, EKG, CBC and SMA/20 were all normal.

Because of the presence of multifocal carcinoma on the left and the antecedent radiation therapy, bilateral total mastectomy with excision of the left lower axillary nodes was performed. The left breast revealed lobular carcinoma *in situ* and fibrocystic disease. Left axillary lymph nodes revealed reactive hyperplasia. The right breast revealed fibrocystic disease and a 1cm focus of infiltrating ductal carcinoma. The patient did well postoperatively.

Discussion

Ionizing radiation is an acknowledged human carcinogen.[1-8] There is ample evidence that exposure of young women to high doses of radiation is followed many years later by the development of breast cancer.[1-8]

Women who survived the atomic bombing of Hiroshima and Nagasaki and were exposed to over 100 rads of ionizing radiation developed breast cancer at 3.3 times the incidence in the normal population.[1,2] A similar increase in the incidence of breast cancer was found in Nova Scotia in a group of women treated by repeated fluoroscopically controlled pneumothoraces.[2] These women received an average exposure of 300 rads.

A group of women similar in age and level of radiation exposure to the patient presented were treated for postpartum mastitis by radiation.[4] These women were treated with a 200KV machine to a mean dose of 377 rads (range 60-1400 rads) and developed breast cancer at three times the anticipated frequency.

The increased risk of developing breast cancer appears to begin at an exposure level of approximately 75-100 rads except in younger women or teen-agers in whom exposure to lower doses of radiation is associated with an increased risk of developing breast cancer.[5-8]

As more cases of radiation related human carcinomas are reported, it becomes obvious that a significant health hazard has emerged from the widespread use of radiation therapy to treat non-malignant diseases. Since breast cancer is a possible result of excessive thoracic radiation, an attempt should be made to identify patients at high risk and to include them in long term followup programs employing physical examinations and mammography.

Although further radiation of previously radiated patients may be unappealing, the reported case is an example of the potential benefit of mammography. The management of the contralateral breast may be debated, but in this case in which there was no dominant mass, the tumor was multicentric, and the amount of radiation exposure was so large, it appeared logical to proceed with a contralateral total mastectomy, a decision justified by the histological findings. ◂

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Pulse

(Continued from page 153)

point empty-handed, it would be wise to become familiar with the business end of the practice and the couple's retirement plans. It is a prudent thing to have the input of professionals, but wives should take time to be informed and to keep abreast of tax changes and current trends. For, as the late Mayor Daley once said, "Ah, the experts, what do they know?"

The comeback trail for those left behind by death is studded with frustrations and painful changes, but there is light and promise at the end of the road. It may wind and at times detour, but it can also be a time of exciting growth, of self-discovery and of new experiences. No one, no matter how loving, can spare one the pain of lonliness and loss, but today's widow and widower (the men have their special problems, too) are more fortunate than those of past decades. There are many fine support and special help groups within the community. I was fortunate to be in touch with the newly formed Widowed Outreach Network (WON) which meets at our community hospital on that most difficult of all days for those alone—Sunday afternoons. The sharing, the "rap" sessions and the socializing were of tremendous help during the initial stages of grief and have continued to form the nucleus of a new social circle of understanding friends. As a widowed auxilian, I would strongly urge the formation of such organizations in communities where the need is not being met. ◂

For further information concerning the above contact Mrs. Klaren through the ISMSA office.

Physician Cost Awareness in Prophylaxis and Treatment of Infection

By Jeffery D. Semel, M.D./Chicago

A survey of seven Chicago-area teaching hospitals was made to determine the acquisition and cost-to-patient prices for various antimicrobial drugs. The results of this survey are presented, along with suggestions for achieving cost-savings in the management of infection. Physician cost-awareness combined with knowledge of antimicrobial pharmacology and spectrum of activity can lead to savings of hundreds of dollars during ordinary prophylaxis or treatment.

In the 50 years since introduction of sulfonamides, many other classes of antibiotics have been discovered. Once an antibiotic is discovered, attempts are often made by chemical modification, to broaden the antimicrobial spectrum, change pharmacokinetic properties and increase safety. The result has been a proliferation of antimicrobial agents. Physicians are expected to become familiar with the pharmacologic and antimicrobial features of each agent.

As the cost of health care increasingly becomes a focus of national attention, it will become incumbent upon physicians to have knowledge of the costs of antimicrobial therapy. The following article describes how physicians' knowledge of antimicrobial pharmacology, spectrum of activity and costs can result in substantial savings.

Methods

A physician was contacted at seven Chicago-area teaching hospitals (both university and non-university) and asked to obtain the price for each of a list of specific antimicrobial agents in a variety of dosages and routes of administration. For each antimicrobial agent an "acquisition" price and a "cost-to-patient" price was requested. The survey was completed in July, 1982.

Results

The dose, route, usual number of daily doses, average single and average daily dose, acquisition price and cost-to-patient price, for each antibiotic is shown for teaching hospitals (n = 7, Table 1). Information related to the dose and usual number of daily doses was obtained from two references.[1,2]

Discussion

There is an important role for the physician in determining the cost of treating an infection. For example, the acquisition price and cost-to-patient price for treating a patient with pyelonephritis due to *Escherechia coli* with cefamandole, 2.0G, IVPB every six hours would be $41.12/day and $147.28/day respectively. If the bacterium, however, was susceptible to ampicillin, and ampicillin, 2.0G, IVPB, was administered instead of cefamandole, the acquisition price and cost-to-patient price would be $9.88/day and $77.24/day respectively. The savings over a one week period of treatment would be approximately $200.00 in acquisition costs and $500.00 in patient costs.

When intravenous therapy is used, a major factor in determining the ultimate cost of therapy is the number of times per day that an antibiotic must be administered. For example, consider the case of a patient with *E. coli* pyelonephritis, in which the organism is resistant to ampicillin, but susceptible to both cefamandole (a second-generation cephalosporin) and cefazolin (a first-generation cephalosporin). Due to a longer half-life, cefazolin can be administered every eight

hours, while cefamandole is administered every six hours. The average daily acquisition and cost-to-patient prices for treatment with cefazolin, 1.0G, IVPB, every eight hours would be $14.31 and $76.47, respectively. If cefazolin were used instead of cefamandole, the savings realized in acquisition costs would be nearly $200.00, and in patient charges nearly $500.00, during a seven day course of therapy.

Intramuscular therapy is usually considerably less expensive than intravenous therapy. By using intramuscular therapy, various charges for preparing a drug for IVPB administration are avoided. For example, the average daily cost-to-patient price for tobramycin, 80mg, IVPB every eight hours, was $76.89. If, however, the same dose of tobramycin were given by the intramuscular route every eight hours, the daily cost-to-patient price was $41.55. The savings incurred in charges to the patient would be nearly $250.00 over a seven day treatment period. In some cases the need for intravenous fluid therapy can be eliminated completely, resulting in further significant savings.

Cephalosporins

The examples cited above show

Table 1
Average, single dose, and daily, acquisition,* and cost-to-patient price, for various antimicrobials in Chicago-area teaching hospitals (n = 7).

				Acquisition cost ($)		Cost-to-patient ($)	
Antibiotic	Amount	Route	No. daily doses	Single Dose	Daily Cost	Single Dose	Daily Cost
Cephalosporins							
Cefazolin	1.0G	IM	3	4.23	12.69	11.61	34.83
Cefazolin	1.0G	IV	3	4.77	14.31	25.49	76.47
Cephalothin	2.0G	IV	4	6.64	26.56	27.48	109.92
Cephapirin	2.0G	IV	4	4.56	18.24	26.25	105.00
Cefamandole	2.0G	IV	4	10.28	41.12	36.82	147.28
Cefoxitin	2.0G	IV	4	13.08	52.32	43.72	174.88
Cefotaxime	2.0G	IV	4	21.52	86.08	56.83	227.32
Moxalactam	2.0G	IV	3	23.83	71.49	60.71	182.13
Penicillins							
Ampicillin	2.0G	IV	4	2.47	9.88	19.31	77.24
Carbenicillin	5.0G	IV	6	5.91	35.46	31.64	189.84
Ticarcillin	4.0G	IV	6	10.20	61.20	39.47	236.82
Mezlocillin	4.0G	IV	6	13.24	79.44	45.06	270.36
Piperacillin	4.0G	IV	6	14.46	86.76	51.43	308.58
Aminoglycosides							
Gentamicin	105mg	IV	3	2.63	7.89	25.25	75.75
Gentamicin	80mg	IV	3	1.33	3.99	19.56	58.68
Gentamicin	105mg	IM	3	2.78	8.34	13.49	40.47
Gentamicin	80mg	IM	3	1.52	4.56	7.65	22.95
Tobramycin	105mg	IV	3	9.07	27.21	33.72	101.16
Tobramycin	80mg	IV	3	5.23	15.69	25.63	76.89
Tobramycin	105mg	IM	3	8.50	25.50	22.67	68.01
Tobramycin	80mg	IM	3	4.67	14.01	13.85	41.55
Amikacin	525mg	IV	2	26.16	52.32	89.21	178.42
Amikacin	500mg	IV	2	12.64	25.28	41.38	82.76
Amikacin	525mg	IM	2	23.98	47.96	83.46	166.92
Amikacin	500mg	IM	2	12.15	24.30	30.21	60.42
Others							
Vancomycin	500mg	IV	4	15.51	62.04	46.12	184.48
Erythromycin	500mg	IV	4	4.82	19.28	25.04	100.16
Clindamycin	450mg	IV	4	11.04	44.16	38.40	153.60

**The doses and intervals selected are those that may be used for severe infection. Some of the dosing recommendations may have changed since the time of the survey.*

Table 2
Cost of prophylaxis of infection during insertion of a prosthetic knee joint. Four possible regimens.

Antibiotic	Dose (G)	Route	Frequency*	No. of days	Total Cost ($) Acquisition	Cost-to-Patient
Cefazolin	1.0	IM	1 dose	1	4.23	12.69
Cefazolin	1.0	IVPB	3 doses	1	14.31	76.47
Cephalothin	2.0	IVPB	Q 6 H	3	86.32	357.24
Cephalothin	2.0	IVPB	Q 6 H	7	192.56	796.92

**First dose at induction of anesthesia*

how physician usage of cephalosporins can influence costs. It is also readily apparent that the newer second and third-generation cephalosporins are considerably more costly than older first-generation drugs such as cefazolin, cephalothin, and cephapirin (Table 1). The physician should, when contemplating using a second or third-generation cephalosporin, ask himself the question, "Would a first-generation cephalosporin be adequate for this infection?" The answer for the majority of infections caused by *E. coli, Klebsiella pneumoniae,* or *Proteus mirabilis* would be "yes". The answer for infections harboring *Bacteroides fragilis* would be "no". However, new, longer half-life, third or fourth-generation cephalosporins being developed may provide increased spectrum and cost savings simultaneously.

In the area of prophylaxis of infection, cost differences can have far reaching impact. For example, several studies have shown that either single dose or short courses of antimicrobial therapy (usually less than three days) have equivalent efficacy to longer courses of antimicrobial therapy in preventing infection during certain types of surgery.[3] Table 2 depicts several possible regimens for the prophylaxis of infection during insertion of a prosthetic knee joint. Depending upon the prophylactic regimen chosen, the prevention of infection for one surgical procedure could cost the patient as little as $12.69 or as much as $796.92.

Penicillins

Carbenicillin, ticarcillin, mezlocillin, and pipercillin are expanded spectrum beta-lactam antibiotics. Their greatest application has been in the treatment of *Pseudomonas aeurignosa* infections, usually in combination with aminoglycosides. These drugs have a short half-life of approximately one hour, necessitating a four hour dosing schedule for severe infections. The high dose required to inhibit *Pseudomonas aeurignosa* and the large number of infusions required daily (six) make this group of drugs among the most expensive. While these drugs are active against other gram-negative aerobic bacteria, a cheaper alternative, usually a cephalosporin, can be selected in most cases.

Aminoglycosides

Among the three aminoglycosides, gentamicin, tobramycin, and amikacin, gentamicin is the least expensive drug. Its acquisition price is approximately one-quarter that of tobramycin, the next most expensive drug. For a patient with normal renal function, weighing 70kg, the use of gentamicin, 105mg, IVPB, every eight hours, instead of tobramycin, 105mg, IVPB, every eight hours would result in acquisition-cost savings of about $130.00, and cost-to-patient savings of about $200.00 over a seven day period.

In prescribing aminoglycosides, it is critically important to take into consideration the age-related decrement in renal function, both with respect to safety and cost effectiveness. For example, if renal function is not properly assessed in a 65 year old female weighing 60kg and having a serum creatinine of 1.3 mg/dl, she would receive 90mg of tobramycin every eight hours IVPB. If, however, the glomerular filtration rate was measured or calculated, using the formula of Cockfroft and Gault, it would be appreciated that the creatinine clearance is only about 50ml/min.[4] One of several available nomograms for aminoglycoside administration would make it clear that a suitable maintenance dose following the loading dose would be 72mg, every 12 hours, IVPB.[5] The potential savings of these relatively simple measures are illustrated in Table 3. The savings over seven days would be approxi-

Table 3
Cost-to-patient of seven days of therapy with tobramycin with and without adjustment for renal function in a 65 year old female, weighing 60kg; creatinine 1.3mg/dl.

Adjustment	Dose	Cost-to-Patient/Week
No	Tobramycin, 90mg, IVPB, q 8 h.	$708.12
Yes	Tobramycin, 90mg, IVPB, followed by 72mg, IVPB, q 12 h, IVPB.	$366.91

mately $340.00.

Renal Insufficiency

In patients with renal failure, an outstanding opportunity exists for physicians to conserve resources. By taking advantage of the prolonged excretion, due to renal insufficiency, of many antibiotics that are normally eliminated via the kidneys, substantial savings are possible. A good example of this is the chronic hemodialysis patient who acquires a staphylococcal infection. The use of a drug such as erythromycin, which is not excreted via the kidneys, would result in much higher charges. The use of cefazolin, vancomycin or other drugs which are excreted by the kidneys results in significant savings.

Antibiotic Combinations

A full discussion of this aspect is beyond the scope of this article. However, it is worthwhile to point out the fact that certain combinations such as some aminoglycosides plus cephalosporins or penicillins may cost the patient nearly $500.00 per day of therapy. Combinations of antibiotics should be reserved for patients who have infections caused by multiple pathogens, or for circumstances in which combinations are of proven benefit, such as in infections in neutropenic hosts, enterococcal endocarditis, etc.

Some studies have examined the use of a second or third-generation cephalosporin as compared to combination therapy in polymicrobial infections. One study, for example, compared the usage of cefoxitin with or without amikacin to that of amikacin plus clindamycin in mixed aerobic-anaerobic infections. Cefoxitin alone was found to be as effective as amikacin plus clindamycin in that study.[6] Therefore, the use of cefoxitin instead of amikacin plus clindamycin for some patients may result in savings of over $1000.00 in charges to patients over a seven day course of therapy.

Summary and Conclusions

(1) Physicians can have a great impact in reducing the cost of treating infection. Both the acquisition price and cost-to-patient price should be considered. Hundreds of dollars may be saved during the course of one or two weeks of treatment. Physicians should have access to price information.

(2) A good knowledge of pharmacology and antimicrobial spectrum is essential to cost-conscious therapy of infection.

(3) For many antibiotics, intramuscular therapy is a less expensive method than intravenous therapy for providing parenteral treatment.

(4) Antimicrobials with longer half-lives are usually less expensive than antimicrobials with shorter half-lives because they require fewer administrations.

(5) An estimate of renal function is necessary in calculating dosages for both *safety and cost-conscious reasons.* It is particularly important to remember that renal function declines with aging.

(6) For prophylaxis of infection the smallest effective dose and the shortest effective course should be selected. Prolonged courses of antimicrobials for prophylaxis should be discouraged. Cost factors should be taken into account in selecting a drug for prophylaxis. The "newest broad-spectrum drug" is usually not required.

(7) Although not addressed in the survey, it is well to remember that antimicrobials are not a substitute for effective surgical drainage. Thousands of dollars can be wasted in charges for antimicrobial therapy when necessary drainage is delayed.

(8) Further research is indicated in determining the minimal effective dosage and frequency of antibiotic therapy for various infections and the role of oral antibiotic therapy. ◀

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The American Way?

Capitalist Medicine

By Jane Jackman, M.D./Springfield

American medicine is being subject to the powerful forces of the market place. There is a move toward bigger organizations, an expected increase in the capitation system of payment, and a large growth in the corporate aspect of medicine. This paper attempts to provide information on these changes, particularly with respect to Illinois.

We are undergoing some revolutionary changes in the 1980's in the way in which medical care is delivered. Health care consumes at least 10% of the GNP, and health insurance in 1982 exceeded the consumer price index by a factor of three.[1] Both the Federal government and private industry are concerned about the high cost of medical care. Together they provide insurance for 85% of the population of the U.S.A. With the recent recession, there has been less money to spend in every area. Medicine is seen as a way to cut spending, since it is widely viewed as having much inefficiency, fat and waste in its traditional, fee-for-service mode of delivery. Industry, in particular, has been quick to seek out alternate delivery forms, such as HMO's and PPO's. American industries are facing increased competition from overseas industry, which does not have to absorb these fast-rising medical costs. A General Motors spokesman stated recently that health care costs contributed $483 to the cost of every GM car and truck produced in the United States in 1982! There has been a growth in all areas of this country in local health care coalitions—groups of businessmen, consumers, health care providers, trade union members, among others, who meet to discuss ways to more efficiently deliver health care in their communities. These organizations, together with the Business Round Table, are busy collecting data on the cost of care delivered by local individual physicians and institutions.

In addition to this, we have an ever expanding supply of physicians graduating from our medical schools. It is estimated that by 1990, four out of every 10 physicians in the U.S. will have graduated in the 1980's. There is already saturation of some specialities in many metropolitan areas—by 1990 there will be fierce competition for patients over most of the country, and HMO's, with their guaranteed income and instant supply of patients, will probably be appealing to young physicians. Women now make up 35% of some medical school classes, and the more structured hours and less frequent night call associated with an HMO position will no doubt be appealing to young women with family responsibilities. Added to these facts, big business is finding large profits in medical care delivery systems, and recent FTC rulings against organized medicine have facilitated their entry into the health care marketplace.[2] Many physicians feel confused and threatened by the rapid changes going on around them, and feel ill prepared by their previous training to deal with these new "business" aspects of practicing medicine (what Jeff Goldsmith, Ph.D., has termed "capitalist medicine.") This article is an attempt to define some of the current systems of alternate health care delivery, since by understanding the changes which are occurring, we will be in a better position to find solutions to the problems that these changes bring.

HMO's (Health Maintenance Organizations)

These are organizations which provide for both the financing and delivery of prepaid health care in one system. The idea of prepaid health care is not a new one. The first American HMO was started in 1721, by a Boston physician entrepreneur, who offered his patients "Five pounds per annum, sick or well!"[3] The HMO subscriber pays a fixed amount each month to the HMO for his total medical care,

but, in return, must receive medical services only from physicians and hospitals designated as care providers by the HMO. There are four different types of HMO models, although there can be considerable overlap between the various types, as newer "hybrids" evolve in an increasingly competitive environment.

Staff Model HMO's—These directly employ physicians, providing them with a central office facility and administration. The physicians are usually salaried, with bonuses provided on an incentive basis, based on the HMO's performance and costs. An example of this type would be the Kaiser Foundation Group.

Group Model HMO's—This model contracts with a multispeciality group practice, sometimes providing a central medical facility. The medical group receives a fixed fee (a "capitation" fee) for each HMO subscriber, regardless of how much the subscriber uses the facility during the coming month. The contracting group then pays its physicians according to its usual practice.

Network Model HMO's—These are similar in structure to the group models, except that the HMO contracts with more than one multispecialty or single specialty group practice. Patients are usually seen in the individual groups' offices, and reimbursement is again on a capitation basis.

IPA's (Independent Practice Association)—In this type of model, physicians see patients in their own offices, rather than in an HMO facility—caring for prepaid patients along with fee for service patients. The physician is usually reimbursed on a fee for service basis, although some groups are switching to a capitation basis. The physician is generally put at financial risk, by withholding a percentage of his fee (usually 10-20%). This will be reimbursed at a later date depending on the IPA's performance. The physician's contract is with an organization of his/her peers—the Individual Practice Association—and so he/she has a voice in the organization and governance of the group. Proponents of IPA's feel that their system is the least disruptive form of HMO, both to the way in which physicians practice medicine, and to longstanding personal doctor-patient relationships. Also, since IPA's use the physicians already present in the community, and utilize their already existing offices, high start up costs are avoided. Opponents of IPA's charge that this is the most inefficient form of HMO—with so many individual physicians to contend with. They also say that the organization becomes unwieldly and bureaucratic, and also less cost-effective than the staff or group model of HMO.[4] Of the 15 HMO's which folded from July, 1982, to June, 1983, 12 were IPA's. However, there are several successful IPA's.

HMO of Pennsylvania showed the largest gain in membership (38,782) of any HMO nationally in the last 6 months. This IPA uses a capitation system to reimburse their primary care physicians. Dr. Weiner, senior vice-president for medical delivery services, stated that "every IPA that is based on fee for service discounts either has already failed or will fail." He feels that the fee for service system provides negative incentives for the physician to be cost effective. Some health care experts expect to see a shift of more IPA's to a capitation arrangement in the future.

Physicians Health Plan (PHP) in Minneapolis is another successful IPA. It was formed by the Hennepin County Medical Society in 1975 and uses the fee for service system. They have a large panel of physicians—in fact the majority of private practice physicians in Hennepin County belong. They have 25% of the HMO market in Minneapolis. In 1975, PHP faced claims for hospital care double those of competing HMO's, in terms of hospital days per thousand subscribers per year (800 per 1,000). By using strict utilization review, they have, to date, halved their number of hospital days to 400 per 1,000. (Hospital costs are the largest item in health care.) The physicians also share in the risk-taking—their fees are reimbursed at 80% of what is considered reasonable, as are most IPA physicians. However, only the *efficient* providers of care are reimbursed the extra 20%. High costs for inpatient or outpatient care trigger a review of that physician's practices. Unexplained high costs deprive that physician of part or all of the 20%. PHP reports that some physicians have chosen to leave the plan, but that most have modified their behavior.[5]

History

HMO's were started in the early 1970's as an experiment in cost containment for health care. The Federal Government aided the formation of many of the earlier HMO's by providing seed money in the form of grants. Currently the Federal Office of Health Maintenance Organizations (OHMO) is not giving Federal grants, but is helping HMO's find capital from the private sector. The HMO Act of 1973 required employers with 25 or more employees to offer their employees an HMO option if it was available locally. This opened up the market for HMO's. HMO's are growing rapidly—the HMO movement of the 1970's is becoming the HMO industry of the 1980's. There was a levelling of growth during the recession, but HMO's have grown very rapidly in the last six months. Interstudy, (a Minnesota research organization) expects them to grow at a 15% rate every year. The number of HMO's has grown from 72 in 1973 to 280 today, but more than 12.5 million people (5.5% of the American population) use HMO's today, compared with 4.4 million in 1973. By 1990 there are expected to be 50 million enrollees in HMO's.

Here in Illinois we are experiencing a significant growth in HMO's, as the storm front, which started in California, is being pushed eastward by the prevailing westerly winds. Currently there are 13 HMO corporations licensed by the Illinois Department of Public Health, and several more are in the process of applying for licensure. (HMO's may be state qualified, federally qualified, or both. Federal qualification has more stringent requirements than state qualification, but in the past allowed the HMO to request Federal financial assistance, and allows the HMO to be marketed to employees of any company with more than 25 workers.)

There are currently 159 actual

facilities operated by HMO's in this state. Most of these are in the greater Chicago area, but the industry is picking up steam in other Illinois cities such as Rockford, Joliet, Champaign-Urbana, Quad cities, Carbondale and Bloomington-Normal. Many cities have more than one HMO. The presence of one HMO in a community means that others will soon follow, in hot competition for patients. Excluding Cook and DuPage counties, there are HMO's in at least 23 towns and cities in Illinois.[7] Factors which will encourage HMO formation are present in these and other cities in Illinois. These factors are an excess of physicians, an excess of hospital beds, a major employer (or employers) and the presence of other HMO's. Starting soon in 1984, Medicare patients will be encouraged to join HMO's. HMO's will receive financial incentives to enroll them as patients. One option they will have is to obtain reimbursement at 95% of the average cost of treating a similar patient in the fee for service system. Because of this, HMO markets will be expanded considerably.[8]

PPO's (Preferred Provider Organizations)

In many cities where HMO's have taken over a portion of physicians' patients, doctors see PPO's as a competitive alternative to HMO's. A report of the AMA Council on Medical Services defines PPO's as follows: "A PPO is a group of hospitals and physicians which contract with employers, insurance carriers, or third party administrators to provide comprehensive medical service on a fee-for-service basis to subscribers".[9] Care is provided on a fee for service basis by a panel of "preferred" providers—usually giving their services at a 15-20% discount. The patient is free to go to any physician or hospital he wishes, but if he does not choose the preferred provider he will have to pay the difference (*i.e.*, the 15-20%) out of his own pocket. Therefore, there are strong financial incentives for patients to go to the "preferred" panel. Examples of the insuring entity could be Blue Cross/Blue Shield (or other insurance carriers), a self-insured employer, or a Union Trust Fund. PPO's do not require high start up costs since existing physicians' offices are used. Little financial risk is involved since the insurance carrier or self-insured employer carries the financial risk. Physicians are promised retaining or expanding their patient base, retaining independent practice in a fee for service mode, quick claim turnaround, and a defense against HMO plans. In return, physicians offer their services at a discount, and agree to submit to strict utilization review. Hospitals like PPO's since they can maintain or expand their patient base and utilize excess beds, get improved cash flow because of quick claim turnaround, increase their percentage of paying patients, and may simplify their paperwork. Employers and employees look favorably on PPO's since they get discounted services, but still retain freedom of choice of physician and hospital (patients may rotate in and out of the plan, depending on who treats them). Employers are able to get utilization review of the physicians and hospitals, and so are more able to collect data, which may be used in future bargaining sessions with providers. Most PPO's have been in operation in California, where state laws encourage their formation. Elsewhere in the U.S., they are forming quickly, but at present there is more talk than action. States such as California, Wisconsin, Minnesota, Florida, Virginia, among others, have passed laws to encourage PPO formation. Some antitrust problems may be anticipated in states which do not have favorable legislation, (Illinois is one of them) although at the Federal level, HR2956 "Preferred Provider Healthcare Act of 1983," may override any restrictive state laws.[10] In Illinois, many organizations are in the process of forming PPO's to start this spring or summer, but at this writing only three were in operation.

Critics of PPO's state that discounting alone will not necessarily lower total medical bills. Walter McClure, director of a Minneapolis group called "The Center for Policy Studies" thinks that "preferred providers" should be those who practice efficient, cost-effective medicine, rather than just those who are willing to accept a discount. "It ain't no bargain if the doctor cuts fees 15% and then increases the care he provides by 50%,"[11] Mr. McClure says.

Some detractors of PPO's, along the same vein, think that the letters PPO stand for "Physician Pimping Organization"! Dr. Paul Elwood of Interstudy, a Minnesota research organization, thinks that PPO's are only a short term solution to long term problems. He thinks that PPO's may develop into HMO's with time, because unless they are very efficiently run they will not result in cost savings. Therefore, larger discounts will be requested at the next contract renewal, or a switch to a capitation basis will be considered. Despite their detractors, many physicians will probably feel a need to join a PPO to retain their market share. It should be noted that in most cases, physicians can belong to any number of PPO's; doctors should therefore beware of "exclusivity" agreements in contracts. Since PPO's are basically an insurance mechanism, insurance companies may be in the best position to institute them. Blue Cross/Blue Shield has instituted some programs, such as "Project Aware" in Minnesota. The idea is also appealing to self insured employers, hospitals, and physicians.

EPO's (Exclusive Provider Organizations)

These have the same characteristics as PPO's *except* that consumers are locked into specific providers or they will receive no coverage. They are closer to a "closed panel." Some of the appeal of a PPO is lost when it becomes an EPO, since there is no longer any choice of physician or hospital.

DRG's (Diagnosis Related Groups)

Yet another ingredient to be added to this cauldron of bubbling alphabet soup arrived in the fall of 1983. Under this system of payment, hospitals are reimbursed for Medicare patients by a fixed amount of money, (dependent on the chief diagnosis) regardless of the actual cost of treating the patient. There are 467 DRG's (356 related to Medicare reimburse-

ment). This system of payment is being phased in over a three year period. Traditionally, Medicare has not paid its fair share of hospital costs generated by its patients, causing cost-shifting to other payors. Since the amount paid out by Medicare under the DRG system will not be higher than under the previous system, the situation is not expected to improve. Any ancillary services provided in the hospitals (tests, respiratory therapy, physical therapy, etc.) will provide a *negative* cash flow to the hospital. Physicians will be monitored closely by the hospitals, and conflicts may be expected to arise if a physician consistently "overspends" for the hospital, by overusing ancillary services, or by keeping patients in the hospital longer than is economically feasible.

By October 1st, 1984, hospitals must have a contract with a Peer Review Organization (PRO) as a condition for Medicare payment. One of the important functions of the PRO will be to ensure that quality of care is not sacrificed in the name of economy, and physicians will need to participate in PRO organization to ensure this.[12]

Physicians may also receive payment for services for hospitalized Medicare patients this year through DRG's. The way in which this may be implemented has not been settled. One suggestion is that either the hospital, or the admitting physician, be given one lump sum payment to be divided among themselves. As third party payors experience a shift in costs as a result of prospective Medicare payments, they may also opt for this method of payment. Blue Cross/Blue Shield of Kansas has already chosen to do this, and the Blues in other states are seriously considering it. Friction may arise between hospital administrators and physicians, in the hospitals' attempts to make their medical staffs behave economically. One creative solution to this problem has arisen in Minnesota—the MeSH concept (*M*edical *S*taffs—*H*ospital Partnership)—proposed by Dr. Paul Ellwood of Interstudy. It assumes that hospitals and medical staffs are dependent on each other, and that by working closely together, savings can be maximized and conflict minimized. The MeSH contract provides for the creation of a separate corporate unit, half owned by the hospital and half owned by the medical staff. Its main functions are to facilitate the management of risk associated with prospective payment. In addition, it can provide capital for expansion into for-profit enterprises (nursing homes, satellite clinics, surgicenters, etc.)[13] The Hennepin County Medical Society in Minneapolis is in the process of drawing up model legal contracts for MeSH plans, and will begin marketing them to hospitals and physicians this spring.

The Corporate Transformation of Medicine

Dr. Relman, editor of the New England Journal of Medicine, warned us three years ago of the "New Medical Industrial Complex", which at that time he estimated to be at least a $40 billion industry (not including traditional pharmaceutical and medical supply companies.) He told us that for-profit corporations were getting into the health care field as never before, in the form of proprietary hospitals, nursing homes, laboratories, home care services, free standing emergency rooms and hemodialysis, among others. He advised us to watch the situation closely, since he suspected that some physicians and health care corporations would be tempted to put profits ahead of the welfare of patients.[14] Since that time health care has become a commercial enterprise. It has been embraced by Wall Street as one of the hottest growth markets to come along in years. National hospital companies now own about 20% of the nation's 7,000 hospitals (*e.g.*, Hospital Corporation of America, Humana, National Medical Enterprises, American Medical International, Lifemark.) These hospitals are also getting into ambulatory care such as HMO's, PPO's, nursing homes, surgicenters, satellite clinics, etc. Independent, not-for-profit hospitals, faced with competition by the for-profit chains, are joining multihospital chains (such as Voluntary Hospitals of America and on a local scale, United Healthcare Illinois). By becoming a part of a larger group, they can cut costs through group purchasing, and have access to venture capital. In order to maintain their market share, and to provide income to support unprofitable hospital divisions, the voluntary hospitals are forming for-profit holding companies. They can maintain their tax-exempt status, while venturing into profit making areas other than acute care. Their business partners may be physicians or other hospitals or businesses. They are creating satellite clinics, surgicenters, birthing centers, imaging centers, etc., as well as getting into areas such as laundry services and credit collection.[15,16] Many of these services infringe upon the traditional domain of physicians, and so hospitals are entering joint ventures with their medical staffs to avoid conflict.

HMO's are also following the trend toward large corporations. Big HMO's are getting bigger, and smaller ones are surviving by merging. Many initially not-for-profit HMO's have gone public since the withdrawal of government funding recently, and finding many willing investors. In Illinois, Maxicare (a California based HMO) took over CNA/Intergroup one year ago. During the first year after the acquisition, enrollment in the Chicago plan grew 30% to 95,000 members, while enrollments in Maxicare's other plans rose 22%. "Our goal is to build a $1 billion company during the decade," said Dr. Wasserman, president of Maxicare Health Plans, Inc. "I doubt if we can digest more than three (new) states a year, while we can do six expansions in existing states in a year." The company has plans in California, Illinois, Wisconsin, Indiana, Texas, Missouri, Utah, and is considered by HMO-USA (a network of Blue Cross/Blue Shield HMO's in 21 states) to be their biggest competitor. They have operations in many larger cities in Illinois.[17] Eleven national HMO companies now account for more than half of all HMO membership. National HMO enrollment is double that of independent HMO's, and over three times that of Blue

Cross/Blue Shield sponsored HMO's. As with the case of hospitals, price competition, cost containment measures and difficulty in obtaining capital financing are motivating HMO's to affiliate with multiunit systems.[18]

Conclusion

The decision for radical change in health care delivery has already been made by a series of unforeseen and mostly unplanned circumstances. It began with our major health insurance companies providing first dollar coverage and cost-plus reimbursement, which provided little incentive for doctors or patients to be cost-effective. It continued with a mammoth hospital building program, and a large increase in the number of medical graduates from our medical schools. We have had an explosion in expensive medical technology, and this, among other factors, has led to postponement of death for many. The increase in the aged population has meant more demand for medical services. All these factors, plus inflation, have meant large increases in medical costs. With industry and government struggling to gain control of spiralling health care expenditures, we are moving into an era where we will be competing against each other on price. As physicians, we are responsible for the control of at least 70% of medical costs, and will have increasing pressures put upon us to curtail medical services. With the assured growth of alternate health care systems, we need to be involved in the organization, planning and decision making processes in these systems. We are the guardians of the quality of care for our patients, and as such, are the only ones who are qualified to monitor that quality. Dr. Relman urges us to exercise "responsible professionalism" by putting our patients' interests above our own, and above that of the corporate ethic with its emphasis on profits at any price! We need to listen more closely to our patients and their purchasers of medical care, the employers, and be prepared to offer cost-effective medical care to the best of our abilities. Physicians will be in a quandry if the current crisis in liability insurance continues, since we are being asked to cut costs in healthcare, but are having to pay out large sums of money for liability insurance.

More and more, employees are seen as a key to controlling healthcare costs. "Wellness" programs are becoming common, with their emphasis on healthy lifestyles and preventive medicine. The latest Rand study has shown that if patients are made responsible for co-payments and deductibles, they utilize medical services less, and as a whole, are not very significantly less healthy with this method than those who get "free" medical care. With the trend to large scale organizations in all areas of medicine, most of us will feel the need to affiliate with a larger organization with time. We will need to study management and marketing techniques, and apply them to our practices in a responsible manner. If we are successful in holding down the cost of health care, we will be able to avoid excessive government regulation in the form of a national health insurance, which seems to be the only other alternative. Dr. McClure stated recently, "If we cannot make the private sector reform work, we will have a public utility in 5-10 years. . . . The choice is not between change and no change, it's *which* change."[20] ◀

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An Overview

Biological Markers in Gynecologic Cancers

BY MORTEZA M. DINI, M.D., AND MADELINE MILLER/CHICAGO

A deep fear of cancer has compelled scientists to search relentlessly for ways to detect cancer early. Currently, biological markers (BMs) appear to hold the greatest promise in detection of the earliest manifestations of malignant growth.

Biological markers of tumors can theoretically be used to detect abnormalities of structure, function or composition at different levels of tumor evolution. If this theory is true, smaller amounts of tumor can be detected at a more treatable stage. Markers could also be used for surveillance after treatment or to monitor the tumor response to therapy.

According to this definition, BM can be classified in four areas.

BM at the Level of the Host "In Toto"

These are usually a result of the effect of the tumor by-products on the homeostasis of the host. For example, it is generally known that unexplained weight loss may be due to a hidden neoplastic process. Clinicians have used this "marker" for detection and post-treatment surveillance of cancer patients. Every clinician can recall a patient who lost weight without any explanation, and tumor was detected only several months or years later. For this reason, determination of patient's weight on every visit during the post-treatment surveillance period is of paramount importance. Unexplained fatigue, lack of stamina and anorexia are all systemic manifestations of tumor process, and these symptoms may be manifest long before the clinical detection of cancer.

BM at the Organ Level

As it is hoped that tumor marker will detect tumors in their early stages, it would be redundant to mention scans and X-rays to detect BM (as far as gynecologic tumors are concerned).

BM at the Tissue Level

Vulva: It is amazing how often a large vulvar lesion is completely missed in an incomplete pelvic examination. Yet we look for a BM for detection of invisible vulvar lesions that are not clinically obvious: toluidine blue staining and colposcopy are helpful in this regard.

Vagina: It is probably true that in a typical pelvic examination by a physician, the majority of the time is spent on inspection and palpation of cervix, uterus and adnexae, and a very minor part is spent on inspection and evaluation of vagina. However, two "markers" could be used to detect vaginal lesions. The first is cytology, when taken properly from vaginal area, *i.e.*, in detection of vaginal adenosis in DES-exposed individuals. The second is colposcopy. Colposcopy has not been of much help in detection of vaginal lesions because it is difficult to visualize lesions on the vaginal wall. Schiller staining probably will be more helpful.

Cervix: This may be detected by (1) inspection and palpation; (2) cytology; (3) Schiller staining or (4) colposcopy and biopsy.

Uterus: This would include the endometrium and the myometrium. In the endometrium, a high index of suspicion in peri- and post-menopausal bleeding, and in asymptomatic women at high risk for development of endometrial cancer (obese, hypertension, diabetic, etc.) is of prime importance. Endometrial cytology by cell sampler, vacutage or Novak's curette, can be especially helpful in this regard.

In the myometrium, any enlargement in size of uterus or leiomyoma during post-menopausal period or development of any new symptoms should raise the suspicion of sarcomatous degeneration.

Ovary and Tubes: Any postmenopausal adnexal masses should be evaluated. A high index of clinical

suspicion probably is the most important factor in early detection of adnexal pathology.

BM at the Molecular Level

Biochemical diagnosis is of greater importance in tumors arising in organs like the ovary because they are not easily accessible to clinical investigation. These substances are either produced by tumor cells (specific) and may be soluble in body fluids where they are detected, or they may be the result of metabolic changes induced by tumor process, as a response of the normal tissue (non-specific) that is being invaded. BM may be synthesized and released by neoplastic tissue into the circulating blood. They are either lacking or may be produced in extremely limited amounts by the original parent cells. The appearance of these BMs is probably the result of derepression of repressed genes in the neoplastic cells. The exact physiologic role of these markers, if any, is not known. They may be biologically active causing ectopic hormone syndromes or they may have a role in the natural defense of the organism against the development of cancer in the form of rejection or tolerance. These tumor markers and the immune response of the host to them play a role in controlling the proliferation of the neoplastic cells and thereby the tumor growth. The immune responses against these tumor antigens can be used as a basis for immunotherapy.

BM may belong to different parts of malignant cells: nuclear, cytoplasmic or membrane structures. They may be biochemical products of the tumor (carcinoembryonic antigen) or the result of the body's response to the tumor. There has been great hope for several decades for the so-called tumor-specific-antigens, or specific substances that were produced only by tumors and not by their normal counterparts. This has proved not to be true in most cases. It has been shown that tumor cells, only "de-repress" or "express" certain normal nucleoprotein material in improper amounts at improper times.[1] A tumor marker to be of any significant value ideally should have the following characteristics: (a) specificity for the malignant process and the tissue type; (b) ready detectability and measurability in biologic fluids; (c) ability to detect the disease or micrometastasis in the pre-clinical state; (d) ability to facilitate identification of the tumor-burden in the body and (e) ability to indicate the degree of response to the treatment and to be useful in detection of recurrence.[1] The existence of so many BMs attests to the inadequacy of each. The type of test that is used depends on the mission that it is expected to achieve. It may be used to screen asymptomatic individuals or to diagnose a specific disease. It can indicate the effect of the test on the patient (degree of invasiveness) or its effect on others (*i.e.*, cost), or to measure its yield and determine whether early diagnosis will lead to better results. The test should be reliable, reproducible, specific, sensitive and acceptable.

The ideal biochemical tumor marker in cancer is human chorionic gonadotrophin. Using radioimmunoassay, HCG is much more sensitive than clinical and radiographic techniques in detection of residual tissue in trophoblastic disease.[2] As a result, thanks to this extremely sensitive marker, monitoring the disease progress, its response to treatment, and termination of therapy can be done on a rational basis.

Even with the availability of a perfect tumor marker, test results may not exactly reflect the clinical situation. Some of this discordance may be due to the following factors:[3] (a) changes in the tumor volume may not synchronously reflect changes in the number of proliferative cells but rather changes in the growth fraction; (b) synthesis and release of BM may change independent of tumor growth; (c) metabolic clearance rates of BM may change due to changes in the function of liver, kidney, etc, and not exactly reflect changes in the tumor cell population; (d) probably only some of the heterogeneous cell population of a tumor produce BM and (e) tumor size cannot often be clinically assessed accurately.

Normal biorhythm may be the source of variations. Blood and urine levels of polyamines, which are elevated in several neoplastic conditions, vary with the phase of the menstrual cycle. Elimination of this cyclic hormonal variation surgically (ovariectomy) or medically (hormonal contraceptives) could change these patterns.[4]

It is unknown at what stage of dedifferentiation of a tumor antigens are secreted. At present state of the art, quantitative measurement of several cancer related antigens may be a useful diagnostic procedure, which is neither absolute nor specific. In the presence of elevated levels of most tumor markers, one must exclude the possibility of parenchymal diseases of nonneoplastic origin. The assay of tumor markers is not always positive in cases of cancer at disease inception.

There is a positive relationship between the concentration of cancer-related antigens and the extension of the neoplastic process.

BMs sometimes increase several months before the metastases become clinically and radiologically evident; they have great diagnostic potential. The limiting factor is their lack of specificity. Because, in practice, repression of a gene during adult life is never complete, trace amounts of oncofetal antigen can be detected in several tissues and occasionally in blood.

Dynamic tests like provoking the liberation of BM may be more useful than measurement of their basal levels.

Use in Patients at High-Risk of Cancer

Detection of genetic-chromosomal disorders may detect Turner's Syndrome patients, who are at risk for development of dysgerminoma, melanoma, etc. Identification of demographic factors will define people (females-black) who are at high risk for development of cervical carcinoma or (females-white) who are at risk for development of breast, endometrial and ovarian carcinomas. Identification of environmental factors, *i.e.*, viruses (herpes simplex, type II) may identify individuals at risk for development of carcinoma of cervix. Dietary patterns like overeating may identify people at risk for development of breast, ovarian and

endometrial cancer; exposure to such drugs as prenatal estrogen (diethylestilbesterol) may identify individuals at risk for development of clear cell adenocarcinoma of vagina. The pattern of sexual practice and numerous sexual partners may indicate people at high risk for development of cervical cancer.[5]

When a test is nonspecific or insensitive, the use of multiple tests may be more helpful in differential diagnosis. Tormey[6] and his colleagues compared the predictive value of a single test (HCG) which identified 45% of postmastectomy patients with positive lymph node status versus eight markers (HCG, CEA, three polyamines and three minor nucleosides) which detected 67% of these patients. In the diagnosis of metastasis, a single test (CEA) detected 74% and eight markers 96.6%.

The factors that have to be considered in application of screening tests are multiple, *i.e.*, medical, ethical, psychological, economic and even legal.

Theoretically the use of BM may lead to earlier detection of disease when there is little or no organ dysfunction and the patient can better tolerate both the disease and the therapy. She will need less supportive therapy leading to reduced expenses and reduced financial as well as psychosocial burden on the family and the community.

Specific BM in Cancer Diagnosis

Qualitative or quantitative variations of the constituents of body fluids can be used as BM. Classification of these markers could be based on: testing method, (immunologic, enzyme activity), function of the compound, (hormones) and ontogeny, (fetal antigens, placental hormones, growth-related compounds).

Oncofetal Antigens

These are antigenic determinants of fetal cells that are normally repressed during adult life and may express in neoplastic conditions. The close relationship between cellular dedifferentiation and neoplasia is well known. There is much evidence to support the fact that neoplastic development *in vivo* and neoplastic transformation *in vitro* are frequently preceded and/or accompanied by the emergence of molecular, morphologic and behavioral patterns characteristic of cells with variable degrees of immaturity. At the molecular level, the presence of fetospecific antigenic determinants in tumors arising from adult tissues is probably indicative of "retrodifferentiation" of these processes.

From all the so-called oncofetal antigens which have been found in human tumors, only a few have been sufficiently characterized to allow clinical trial and application and even fewer have incited medical interest. In fact, only two are important, namely, the AFP and the CEA. These are discussed below. The other BM, which have not been studied as intensively, will receive briefer treatment.

Carcino-Embryonic Antigen (CEA)

CEA is a glycoprotein which is water-soluble and a membrane antigen with an MW of about 200,000 dalton present in the glycocalyx of the tumor cells. CEA does not have specificity for any single type of tumor. It is found in tumors developing from different sites, such as gastrointestinal tract, lung, breast, urinary tract and gonads.

CEA-like molecules are a family of molecules which share common antigenic determinants. Ovarian CEA appears to be immunologically identical to colonic CEA.

It may be elevated in cervical, uterine and ovarian carcinomas.[7,8] However, because of high false positive rate, its value for screening purposes may be limited. In a Van Nagell, *et al*,[9] series, 10/11 patients with ovarian cancer showed CEA levels more than 2.5ng/ml by using plasma method of 2-gel precipitation. Seppalla, *et al.*,[10] observed that 21% of 53 patients with ovarian cancer had levels exceeding 5ng/ml. Khoo and McKay[11] reported that 67% of 109 patients with ovarian malignancies gave levels of 5ng/ml or more.

Khoo, *et al.*,[12] demonstrated CEA in moderate amounts in tissue extracts of several histological types of ovarian cancer. Khoo and McKay[11] prospectively studied serum levels of CEA in patients with ovarian cancer, and related these levels to histology, tumor differentiation, clinical stage of disease, response to cytotoxic drugs and long term prognosis. They found that CEA levels were significantly raised in patients with most of the histological varieties of ovarian tumors especially in those with serous cystadenocarcinoma (77%) endometroid (69%) and mucinous cystadenocarcinoma (41%). An inverse relationship was found between CEA and tumor differentiation; 94% of those with poorly differentiated tumors had elevated levels of CEA versus 43% in those with well-differentiated lesions.

A direct relationship was found between the incidence of elevated levels of serum CEA and clinical stage of ovarian cancer (48% in Stage I vs. 90% in Stage IV).

In the majority of their patients, a direct relationship between the tumor mass and the serum level of CEA was observed. In two patients with obvious progression of disease, a paradoxical decrease in serum CEA level was noted. In summary three features of the ovarian tumor with significant influence on the CEA results were histologic type, tumor differentiation and clinical stage.

It was found that serial CEA levels were valuable in follow-up of patients with ovarian malignancy.

Serial CEA levels would indicate the adequacy of surgical resection,[12] detection of recurrence[13] and response of the tumor to chemotherapy or radiotherapy. It is obvious that trends, rather than absolute quantitative levels, provide a better guide to tumor status. Review of the pertinent literature implies that CEA levels should be interpreted in the context of the overall clinical picture, since day-to-day fluctuation and paradoxical changes relative to the tumor mass can be observed. Overall, in ovarian carcinoma, elevated CEA levels are associated with a poor prognosis.

Khoo and McKay also observed elevated levels of CEA in 60% of 183 patients with uterine cervical cancer and 77% of 61 patients with corpus cancer. CEA has been used in differential diagnosis of genital

malignancies.

Parente and Greston[14] used CEA levels to differentiate malignant tumors of the female reproductive tract from extragenital carcinomas preoperatively. CEA level less than 10ng/ml was found to indicate the former and more than 20ng/ml to indicate the latter.

Alpha-Fetoprotein

This alpha-globulin is the dominant serum protein in the early embryo, which is replaced later by albumin. Its molecular weight is about 70,000. In the human embryo it is produced first by the yolk sac and later by the liver. During adult life, the only normal state in which alpha-fetoprotein is raised is pregnancy. In human germinal cell tumors, AFP is synthesized in the epithelium of endodermal origin lining the cyst and tubules in the endodermal sinus (yolk sac) tumors. Tsachrda, *et al.*,[15] demonstrated that in 16 of 19 patients with teratocarcinoma with elevated AFP, endodermal sinus (yolk sac) tumor elements could be demonstrated. Elevated AFP has been reported in primary hepatomas, germ cell tumors, hepatitis, cirrhosis and metastatic liver disease, and in various endodermally derived malignancies of the gastrointestinal tract, pancreas, lung and breast. AFP is elevated in up to 94% of children with endodermal sinus tumors. Monitoring of AFP should begin prior to surgery. These indicators are useful in cases with incomplete resection or metastatic disease and may be used to document response to medical management and recurrence. Nonspecific elevation of AFP may occur in certain nonmalignant disorders: viral and chronic active hepatitis, cirrhosis and ulcerative colitis. It is also elevated in amniotic fluid and in maternal serum in association with fetal anomalies including neural tube defects and complications of pregnancy.[16]

AFP is useful in detection and monitoring yolk sac tumors, embryonal carcinoma,[17] mixed tumors with endodermal sinus or embryonal elements and teratomas. AFP is found exclusively in hepatoma and teratoma so it does not appear to be an essential tumor marker in screening of patients suspected to be suffering from nonteratomatous gynecologic malignancies.

Human Chorionic Gonadotropin (HCG)

Under normal conditions, HCG is secreted in pregnancy by the placenta and maintains corpus luteum function. It is a glycoprotein with MW of 100,000 and an alpha and beta subunit. Because of close similarity of the alpha subunit sequences of HCG and HLH, cross reactivity exists by RIA. However, HCG-Beta subunit has 20 more amino residues than the beta subunit of HLH, FSH and TSH. HCG has been used to diagnose and monitor trophoblastic disease (choriocarcinoma, hydatidiform mole and teratocarcinoma with trophoblastic elements.)[18] A variety of neoplastic processes can produce ectopic HCG. Approximately 40-60% of patients with germ cell tumors will produce measurable levels of HCG.[19]

HCG is positive in 42% of cases of adenocarcinoma of the ovary.[20] HCG may be elevated in nongonadal tumors such as pancreatic (33%), lung (9%), gastric (24%), hepatic (17%), breast carcinomas (12%) and melanomas (10%).[20] In trophoblastic and non-trophoblastic tumor patients HCG may be secreted as a whole, or as alpha or beta subunits.

Human Placental Lactogen (HPL)

HPL may be elevated in the serum of pregnant women and in gestational, gonadal and extragonadal trophoblastic disease. It declines rapidly in cancer patients when a complete response to chemotherapy occurs. A low residual concentration indicates incomplete response. In contrast to HCG, the degree of increase in trophoblastic disease is less than during pregnancy. The ratio of HPL to HCG concentrations may be used to distinguish trophoblastic neoplasia (which is low) from normal gestational trophoblastic tissue (which is high).[21] Nontrophoblastic tumors may produce HPL.

Combinations of oncofetal antigens may be used. In germ cell tumors, AFP and HCG may have the following combinations: in seminoma and teratomas both are usually negative; in embryonal carcinoma AFP and HCG may or may not be positive. They are of diagnostic use in tumors of extraembryonic structures: in yolk sac tumors, AFP is positive and HCG is negative whereas in choriocarcinoma AFP is negative and HCG is positive. HPL and HCG are normal products of trophoblastic tissue and are measurable in the serum of pregnant women. Measurement of HCG and HPL levels have been of great help in the diagnosis and chemotherapeutic management of patients with trophoblastic disease. Because of the cross reactivity of HCG and LH, measurement of beta-subunit by RIA has been of much help. Detection of HCG and HPL in non-pregnant females is always abnormal, while there are other normal hormones that may be produced by a tissue not normally producing that hormone (ectopic production).

Human Placental Alkaline Phosphatase (PAP)

PAP (Regan Isoenzyme), which differs from the hepatic enzyme in terms of electrophorectic mobility, heat stability, catalytic activity and immunochemical specificity, has been studied. This enzyme is produced by the placental trophoblast and is measurable in maternal serum after the first trimester. It is absent from the serum of the fetus, men and nonpregnant women. It is produced at a lower level in gestational choriocarcinoma than in normal pregnancy. It has been shown that the identities of placental and malignant forms are similar.[20] PAP could be demonstrated in a variety of tumors including lung, ovarian and cervical squamous cell *in situ*.[20]

Human Placental Thyrotrophin

This hormonal activity has been described by several investigators. The duration of action of this hormone is intermediate between human pituitary thyrotrophin and the long-acting thyroid stimulator of Graves disease.[22]

Hypercalcemia

This may be asymptomatic or present with anorexia, constipation, polyuria, drowsiness or coma. It

could be due to bone resorption secondary to metastasis or circulating PTH-like immunoreactive substances.[23] Hypercalcemia may be associated with tumors of the ovary, uterus, cervix, bladder and breast. It has been reported to be a grave prognostic sign and may be intractable even with appropriate medical management.[24]

Inappropriate Secretion of Antidiuretic Hormone

This could be a manifestation of the tumor *per se*[25] or following chemotherapy with vincristine or cyclophosplamide.[26]

A variety of ectopic hormones have been implicated with varying degrees of documentation, such as erythroprotein, calcitonin enteroglucagon, prolactin, TSH, renin and FSH.[5] Steroidal hormones like estrogen, progesterone and androgens are elevated in ovarian stromal tumors.

Biologic Amines and APUD Cell Tumors

Excessive tissue levels of the amine precursors, tryptophan, histidine and dihydroxyphenylalanine (DOPA), serotonin, 5-hydroxytryptamine, histamine and dopamine may be found in APUDomas. It was found in one study that 86% of patients in whom metabolites returned to normal had prolonged survival, while all subjects whose excretion levels failed to return to normal ultimately died.[27]

Enzymes

The activity of cellular enzymes and enzymes in body fluids has been used in primary cancer diagnosis, as well as for the recognition of metastatic disease, because certain enzymes or isozymes are quantitatively disease, tissue or organ-specific.[28]

Some enzymes may be reliable monitors for the existence of liver metastases, since their values increase little or not at all in cases of toxic liver damage (5-nucleotidase and alkaline phosphatase). A common problem in oncology is the distinction between disorders of the liver, metastatic involvement, hepatocellular toxicity from chemotherapy and infectious processes of the liver in the immuno-suppressed host.[29] Normal 5-nucleotidase and gamma glutamyl transferase suggests toxic damage. Alanine aminotransferase is useful for detecting early toxic effects from therapy or adapting therapy during its course to the condition of the liver of the patient. Elevated CEA associated with elevated gamma glutamyl transferase suggests liver metastases while a benign process is likely if CEA is normal.[30]

Polyamines

Blood or urinary polyamines, putrescine, cadaverine, spermine and spermidine may be used to monitor the clinical response and recurrence.[31]

Hydroxyproline

Bony metastasis is usually associated with elevated serum level of hydroxyproline.[32] It was reported that in patients with bone metastasis, the clinical or X-ray response was associated with a decline in the hydroxyproline to creatinine ratio.

Urinary Nucleosides

These may be elevated in urine in patients with ovarian or other diseases.[33] These compounds include pseudouridine, methyladenosine and N^2, N^2-dimethyl guanosine.

Serum Ferritin

This has been reported to be elevated in several neoplastic processes including uterine carcinomas.[34] It is unclear whether this elevation is due to increased ferritin synthesis, reticulo-endothelial iron storage or release by necrotic tumor tissue. An alpha-2 globulin called alpha-2H may be elevated in cancer patients.[35] Serum copper and zinc have been reported to be elevated, normal or decreased.[36] It was reported that copper to zinc ratio was elevated during active disease. Both the zinc level and the ratio were normal during remission. Elevation of ceruloplasmin in cancer may be related to an "acute phase" reaction, abnormal copper or iron metabolism, or some other unknown mechanism.[35]

Tumor Associated Antigens

TAA in ovarian cancer has been demonstrated and purified by several investigators. Gall, *et al*[37] demonstrated TAA in extracts of tumor tissues. Levi *et al*[38] observed a similar TAA in tumor cells in culture. Battacharya and Barlow[39] purified a highly specific TAA which was glycoprotein in nature. Knauf and Urbach[40] described the quantitative rather than qualitative differences of TAA in benign and neoplastic conditions. The Framingham study[41] reported that elevated TAA levels could be detected prior to the diagnosis of cancer.

Using an immunoperoxidase technique we could demonstrate TAA in 91% of tissue blocks with a diagnosis of squamous malignancy of the cervix, 45% with carcinoma-in-situ but none of those with dysplasias. With the development of hydridoma technology and the availability of monoclonal antibodies, biological marker and tumor antigens will gradually become more important. The specific monoclonal antibody may be used for serotherapy, conjugate therapy (*i.e.*, radioisotope and chemotherapy conjugates) or for selective elimination of some cellular subsets.[41]

Cancer Diagnosis Using Cellular Properties

Steroid and glucocorticoid receptors are employed when receptor determination is used in initial evaluation of breast cancer patients to select the most appropriate therapy (*i.e.*, hormonal manipulation and chemotherapy). It is increasingly applied to gynecologic tumors (*i.e.*, ovarian and endometrial) but their use as a BM for early detection probably is not relevant at this time.

Conclusion:

Gynecologic malignancies continue to be major causes of mortality and morbidity. As far as early detection of malignancies of the lower genital tract is concerned, (vulva, vagina, cervix and endometrium) clinical examination with intelligent use of cytology, colposcopy, and biopsy is the best screening and diagnostic technique. Screening for malignancies of the upper genital tract (fallopian tubes and ovaries) is more elusive.

In spite of extensive work and

ambitious programs for identification of biologic and tumor markers for early detection and more effective cancer therapy, few practical gains have been realized. Although there are potentials in biologic markers for this function, both great optimism and great pessimism are unrealistic.

At present, biologic markers are not recommended for screening purposes in gynecologic malignancies. This negative approach is due to the low prevalence of these diseases in the general population and the fact that these tumor markers do not have the sensitivity or the specificity necessary to detect otherwise asymptomatic localized malignant tumors. Routine clinical application of these markers should await further refinement and knowledge. Clinical and pelvic examination and a high index of suspicion are still the best. These markers are of some value in the diagnosis of certain specific types of cancer, such as trophoblastic neoplasia and endodermal sinus tumor. Their assay can be used as an adjunct to clinical and pathological staging methods in the context of other findings. They are valuable for monitoring tumor load in certain tumors. ◀

References

A complete list of references for "Biological Markers in Gynecologic Cancers: An Overview," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Public Health

Ambulatory Surgical Treatment Center Licensing Board

The ASTC Board has recommended that IDPH amend the Ambulatory Surgical Treatment Center Licensing Act to clarify the definition of an ASTC. Currently, any facility "primarily devoted to surgery" is required to be licensed as an ASTC. The trend toward more office-based surgery and the development of new technologies which permit physicians to perform procedures outside the hospital, have convinced the Board that the current definition of an ASTC is inadequate and could result in requiring some physicians' offices to obtain an ASTC license.

While no specific definition has been proposed, the Board favored limiting licensure requirements to facilities which were: (1) physically and administratively separate from a hospital; (2) exclusively devoted to surgical procedures; (3) set up to discharge patients the same day as their surgery; (4) appropriately staffed and equipped; and (5) available to any physician who met the standards set for staff members using the center.

(Source: June 6, 1984 meeting of the ASTC Licensing Board.)

From the Department of Children and Family Services

Child Injury Prevention Study Group

The Department of Children and Family Services (DCFS) has entered into an agreement with the Child Injury Prevention Study Group, a corps of medical specialists, to provide consultation to both physicians and DCFS staff in determining whether a child's injuries were accidental or inflicted.

Expert medical opinion will also be obtained when parents or caretakers are charged with medical neglect for failing to obtain proper care and treatment for an ill or injured child.

The objective of the agreement is to provide physicians with accessible consultation when they believe a patient seen in their office has been a victim of child abuse. The Department believes reporting by private physicians will increase with the availability of this resource.

The plan will first be implemented in the Department's Springfield, Peoria and Champaign regions. In addition, the Family Stress Consultation Team, which consists of professionals from a variety of fields, will consult with physicians and DCFS staff on high risk cases.

The project will include a training program that will help medical professionals sharpen their skills in diagnosing child abuse and assessing various risks to the child victim. The training sessions will include simulated child abuse situations and role-playing.

(Source: DCFS news release, May 21, 1984.)

From the State Board of Education

Board Votes to Eliminate School Health Mandates

The State Board of Education and the Superintendent of Education have adopted recommendations to eliminate the financial penalties for schools permitting non-immunized students to attend classes. The Board also adopted a recommendation to eliminate the fifth and ninth grade physical examinations from the School Health Mandates. The next step is for the Board to submit legislative proposals in the next General Assembly session to repeal those provisions from state law.

ISMS and several other medical and public health organizations submitted testimony at public hearings to oppose repeal of these two provisions. Despite these objections, the Board determined that while desirable, these requirements are not a necessary role for schools.

(Source: Minutes of the May 10, 1984 Meeting of the State Board of Education.)

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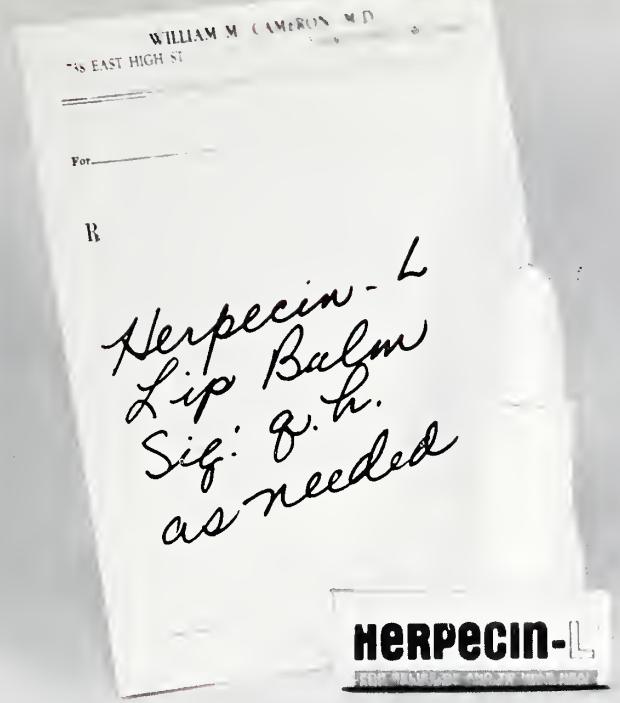
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November 12-16
Flexible Fiberoptic Sigmoidoscopy
November 17
Current Problems in Pediotrics
December 3-7
Speciolty Review in Thorocic Surgery
January 7-12
Comprehensive Course in Emergency Nursing
January 21-23
Modern Cardiology and Technology
January 16
Modern Cordiology ond Technology
January 23
Speciolty Review in Generol Surgery, Port II
January 28-February 8
Modern Cardiology ond Technology
January 30

For further information, write:
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*Additional diagnositic information on page 154

OB-GYN—PEDIATRICIAN TEAM

New Hospital Opening
In Fall of 1984
In Fulton, Missouri

This represents an outstanding medical practice opportunity. County of 30,000 primary service area with fine small community of 12,000+ hosting two nationally known colleges and a growing industrial base. We are close to the Lake of the Ozarks as well as multiple other recreational opportunities and facilities. The hospital has a fine tradition of strong family-practice physicians and has recently recruited an orthopedic surgeon to build its surgical team to two. There are over 400 births in this county each year, and the pediatric population is growing steadily. Residents want the best in specialist medical care. For further information regarding guarantees or other considerations contact Sharon R. Heinlen, Administrator, Callaway Community Hospital, Hospital Drive, Fulton, MO, 65251, 314-642-3376.

ISMS 1985 Travel Programs

February 2-18—*South China Sea Cruise*
Bangkok, Brunei, Kota Kinabalu, Manila, Canton, and Hong Kong

March 20-April 3—*Egypt to Kenya*
Cairo and Nairobi

June 26-July 8—*British Isles*
Ireland, Scotland and England

June 28-July 7—*Canadian Rockies*
Edmonton, Jasper, Lake Louise, Banff, Victoria and Vancouver

July 8-22—*Scandinavia*
Stockholm, Helsinski, Oslo, Copenhagen, Swedish Archipelago

July 23-August 1—*Alaskan Sea Cruise*
Vancouver, Juneau, Skagway, Glacier Bay, and Sitka

August 12-26—*Waterways & French Chateaux Country*
Amsterdam, Cruise through Holland and Belgium, Reims and the Loire Valley and Paris

October 7-22—*China/Yangtze River*
Beijing, Sian, Yangtze River, Shanghai and Hong Kong

Reservations cannot be accepted without the official form printed in promotional brochures, mailed to all ISMS and auxiliary members at least five months in advance. Persons outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact the travel department at ISMS headquarters.

THORACIC SURGERY CASES

The Illinois Thoracic Surgical Society has agreed to furnish brief summaries of case reports related at their regular meetings. These case reports, published on a "space available" basis, are edited by Ralph Butz, M.D., assistant chief, thoracic surgery, Edward Hines Hospital, Hines, Illinois.

Case Presentation by
C.R. Mohan Rao, M.D./ Palos Heights

A 24-year-old immigrant had a fracture of the right clavicle pinned six years earlier in his native Poland. He had been refused employment because his chest X-ray showed that the pin had migrated into the anterior mediastinum. Using a left anterior incision through the bed of the resected third costal cartilage, the pin was extracted. The point of the pin had penetrated the pericardium but without injury to the heart and without pericarditis. No other mediastinal structures were involved. The patient recovered uneventfully.

Meeting Comments

C.F. Kittle, M.D., by way of comment, presented a similar case from his file.

That case, of a teenager with a right clavicle fracture fixed with K-wires, demonstrated the fracture of the wires and their drift into the mediastinum. Xrays showed broken wires with distal fragments extending into the anterior mediastinum. These wire fragments were removed uneventfully through a left thoracotomy.

Summary of Other Meeting Comments

Clavicular fractures rarely require internal fixation. When internal fixation is used, a bone plate will avoid the complication under consideration. Use of threaded pins and early removal have to some extent been helpful. Smooth pins, however, are known to drift into the anterior mediastinum, even pins into the clavicle thru the acromio-clavicular joint. Haas, *et al*,[1] reported a constrictive pericarditis precipitated by a nail migrating into the pericardium, a complication avoided in the present case. There was general agreement among the fellows that residual pins present a sufficient hazard to warrant removal through chest incision if they cannot be removed from the original orthopedic incision.

References

1. Haas R., Lea, R., Sbokos, C., Conway, N.: *Thorax* 34: 559-560, 1979.

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago IL 60603.

BEARDSTOWN:
Family practice with Obstetrics. Join four man group—West Central Illinois—50 bed modern accredited hospital. Salary plus benefits for first two years, leading to opportunity to become equal stock holder. 40 miles from major medical and educational center. CONTACT: Beardstown Clinic, Beardstown 62618 (217-323-2245).(11)

BLOOMINGTON:
Internal Medicine—to join an active six member group of general internists in Bloomington—Normal, Illinois. Subspecialty in rheumatology or pulmonary medicine desirable, but not necessary. Contact: Judy Buchanan, administrative director, The Health Center, 702 N.E. Street, Bloomington, Ill. 61701. (309) 827-5051. (8)

GIBSON CITY:
Internist/Cardiologist—Excellent opportunity in East Central Illinois; modern, well equipped hospital, sophisticated ICU, attached private SNF: new professional office space and incentives available; rural community within 30 minutes of major university, tertiary care center, metropolitan area with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Director, Gibson Community Hospital, Gibson City 60936. 217-784-4251. (8)

GLEN ELLYN:
Expanding multi-specialty group in far western suburbs of Chicago seeks 2 internists. One position involves general internal medicine practice; the other will be essentially a five day per week institutionally based practice with little night or weekend responsibility. Area has excellent schools, housing and recreational facilities. Write: Dave Bauer, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Avenue, Glen Ellyn, Ill. 60137 (312) 469-9200. (8)

GLEN ELLYN:
Internist to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. CONTACT: Dave Bauer, Administrator, Glen Ellyn Clinic, SC, 454 Pennsylvania Ave., Glen Ellyn 60137. (11)

GLEN ELLYN:
Progressive five physician OB-GYN department in 60 physician multispecialty group seeks 6th associate. Attractive location in western Chicago suburbs. Very good family opportunities and professional growth. Excellent hospital facilities backed with strong neonatal program. CONTACT: Dave Bauer or Joseph Nigro, M.D., Glen Ellyn Clinic, SC, 454 Pennsylvania Ave., Glen Ellyn 60137. (11)

KEWANEE:
Population 16,000. Opportunities in Urology, Orthopedics, and Family Practice (solo or associate). Onehundred fifty miles from Chicago, between Peoria and the Quad Cities. Assistance in establishing practice available. Contact: William H. Thieben or Glenn A. Doyle at Kewanee Public Hospital, 719 Elliott Street, Kewanee, Illinois 61443. (8)

MOUNT CARROLL:
Family Practioner, establish solo practice. Tired of traffic, pollution and crime of city living? We offer an alternative. Small, historic community in beautiful northwest Illinois, ten miles east of Mississippi River. Great outdoor recreation, excellent quality of life. Office space remodeled to suit, financial assistance negotiable. Hospital—10 minute drive. Contact Laurie Scott, P.O. Box 3, 623 S. Clay, Mount Carroll, IL 61053; 815/244-1173(W), 1775 (H). (10)

RED BUD:
Orthopedic surgeon needed to serve our community. Thirteen active members on the medical staff including family practitioners, general surgeons, internists, and obstetricians/gynecologists. A 105 bed acute care institution and a free standing ambulatory care center located 14 miles from hospital; also owned by hospital. Located 40 miles from downtown St. Louis. This opening presents an excellent practice opportunity to have a busy practice in a rural community. The educational and social amenities of the St. Louis metropolitan area are within 30 minutes yet you may live in the peace and serenity of a rural community with one of the highest rated school systems in the state. A full service and fully equipped institution available in town. Contact H. Herman, Executive Vice President, St. Clement Hospital, Red Bud 62278. (618) 282-3831. (9)

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GRADUATION DATE _____ **DEGREE** _____

SPECIALTY AREA OF INTEREST _____

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510 Chicago, IL 60603, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

OCTOBER

Endocrinology and Metabolism

Recent Advances in the Diagnosis and Management of Endocrine Related Disorders
For: MDs. Seminar, October 11-12, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $200. **Reg. Limit:** TBA. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours; AOA, 14 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Pediatrics

New Perspectives in Pediatric Hematology/Oncology—Focus on the Practice Aspects of Diagnosis and Management
For: Pediatricians. Course, October 12-13, Chicago. **Sponsor:** The University of Illinois College of Medicine at Chicago, Department of Pediatrics, 912 S. Wood Street, Chicago 60612. **Fee:** TBA. **Reg. Limit:** TBA. **Credit:** Category 1, 14 hours. **Contact:** Conferences and Institutes. **Phone:** 312-996-8025

Care of the Seriously Ill Child
For: MDs. Symposium, October 10-11, Indianapolis, Indiana. **Sponsor:** James Whitcomb Riley Hospital for Children & Indiana University Medical Center, Indianapolis, Indiana 46223. **Fee** $85.00. **Reg. Limit:** None **Credit:** Category 1, 10 hours. **Contact:** Jay L. Grosfeld, MD. **Phone:** 317-264-4681

Neurology

Diagnosis and Management of Strokes
For: Neurologists, MDs. Symposium, October 12-13, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin 53705. **Fee** $165.00. **Reg. Limit:** None **Credit:** Category 1, 11 hours. AAFP Prescribed, 11 hours. AOA, 10 hours. University of Wisconsin-Extension CEUs, 11 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Internal Medicine

Therapeutics 1984
For: MDs. Symposium, October 20, 8am-5pm, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, Wisconsin 53705. **Fee** TBA. **Reg. Limit:** None. **Credit:** Category 1, 6 hours. AAFP Prescribed, 6 hours. AOA, 6 hours. University of Wisconsin-Extension CEUs, 6 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

American College of Legal Medicine Conference
For: MDs, Deans, Faculty. Conference, October 31-November 1, Chicago. **Sponsor:** American College of Legal Medicine, 213 W. Institute Pl., Chicago, 60610. **Fee:** $125.00. **Reg. Limit:** 75. **Credit:** Category 1, 12 hrs. **Contact:** Association of American Medical Colleges, Ms. Betty Hanna.

Surgery Clerkship Design and Evaluation Workshop
For: MDs. Workshop, October 17-19, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBA. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711.

Psychiatry

Comprehensive Psychiatry Review: Part II: The Psychiatric Interview
For: Psychiatrists. Course, October 25-27, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, Illinois 60637. **Fee** $375.00. **Reg. Limit:** None. **Credit:** Category 1, 17 hours. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Health & Sports Science

LaCrosse Health and Sports Science Symposium
For: MDs, PTs, RNs, Nutritionists. Symposium, October 17-20, Civic Center, La Crosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program, 221 Mitchell Hall, University of Wisconsin, La Crosse. **Fee** $225 early, $250 regular. **Reg. Limit:** None. **Credit:** TBA. **Contact:** Philip K. Wilson. **Phone:** 608-785-8686

Cardiovascular Disease

Second Annual L. R. Nelson Cardiovascular Conference
For: MDs, CV Nurses and Technicians. Conference, October 13, Peoria. **Sponsor:** Methodist Medical Center of Illinois and the Methodist Medical Center Foundation, 221 N.E. Glen Oak, Peoria 61636. **Fee:** $15. **Reg. Limit:** 125. **Credit:** Category 1, 5 hours. **Contact:** Irving Favus, M.D. **Phone:** 309-672-5737

Doppler and Two-Dimensional Echocardiography Workshop
For: MDs, Technicians. Lecture, Workshops, October 16-19, 8:00-4:30PM, Chicago. **Sponsor:** Northwestern University Medical School, 250 E. Superior, Chicago, IL 60611. **Fee:** $350.00. **Reg. Limit:** 180. **Credit:** Category 1, 26 hrs. **Contact:** Sharon Joseph. **Phone:** 312-649-4687.

Computer Medicine

Patient Care Enters the Computer Age
For: MDs. Conference, October 29, 9:00-4:30PM, Chicago. **Sponsor:** Northwestern Memorial Hospital, 259 E. Erie, Chicago, IL 60611. **Fee:** TBA. $65.00. **Reg. Limit:** TBA **Credit:** .6 CEU. **Contact:** Jeanette Wisdorf. **Phone:** 312-649-6910.

Medicine and Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, October 29, 4:30pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

ICCME offers two unique 3-hour seminars for leaders of a hospital medical staff or medical society. The ICCME "Leadership" seminar and the "Evaluation of CME Process" seminar can be offered at a location of your choice.

"Technological Options in CME" is the theme of the Annual Illinois Congress on CME to be held October 19-20, 1984 at the Drake OakBrook Hotel, in Oak Brook, Illinois.

(For each of these program offerings—please contact ICCME staff for further information.)

Gynecology

Colposcopy and Clinical Management of Cervical Cancer
For: MDs. Lecture, October 26, Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** $100/MDs; $40/Others. **Reg. Limit:** None. **Credit:** Category 1, 8 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Understanding and Preventing Perinatal Morbidity
For: MDs. Symposium, October 26-27, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711.

Radiology

4th Annual Breast Imaging Conference
For: Radiologists and Technologists. Lecture and Workshops, October 14-16, Madison, Wisconsin. Sponsor: University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, Wisconsin 52705. Fee: TBA. **Reg. Limit:** None: **Credit:** Category 1, 18 hours. University of Wisconsin-Extension CEUs, 18 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

NOVEMBER

Internal Medicine

Advances in Internal Medicine
For: Internists. Lecture, November 12-16, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $500.00. **Reg. Limit:** 20. **Credit:** Category 1, 35 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Fiberoptic Esophagogastric Endoscopy
For: MDs. Lecture, November 12-14, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $490.00. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Flexible Fiberoptic Sigmoidoscopy
For: MDs. Lecture, November 17, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $145.00. **Reg. Limit:** 75. **Credit:** Category 1, 7 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Cardiology

Current Cardiology: Adults
For: MDs. Lecture, November 5-8, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee** $395.00. **Reg. Limit:** 90. **Credit:** TBA. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

2nd Annual L.R. Nelson Cardiovascular Conference
For: MDs, RNs, Techs. Conference, November 3, 9:30am-2:30pm, Peoria, Illinois. **Sponser:** Methodist Medical Center of Illinois and The Methodist Medical Center Foundation, 221 NE Glen Oak, Peoria, IL 61636. **Fee** $15.00. **Reg. Limit:** 100. **Credit:** Category 1, 5 hours. **Contact:** Irving Favis, MD. **Phone:** 309-672-5737

Current Cardiology: Children
For: MDs. Lecture, November 9-10, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $340.00. **Reg. Limit:** 90. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

October 19-20, 1984

Twelfth Annual ICCME Congress: "Technological Options in CME"

The focus of the Congress will be to assist registrants in understanding and applying advances in communications technology to the development and implementation of quality continuing medical education programs.

Keynote Speakers:

Patrick B. Storey, M.D.
President, Alliance for Continuing Medical Education
Associate Dean, University of Pennsylvania School of Medicine, Philadelphia, PA

Beverly Hill, Ed.D.
Director, Medical Education Resources Program
Indiana University School of Medicine
Indianapolis, IN

Twenty-five small group workshops will deal with the application of various learning techniques to advanced technology now used in offering CME. Congress attendees will have an opportunity to view a display of a variety of state-of-the-art CME technology.

For additional information, contact the Illinois Council on Continuing Medical Education, 55 E. Monroe, Suite 3510, Chicago, IL 60603, (312) 236-6110.

Cardiac Rehabilitation Workshop
For: MDs, RNs, PTs. Workshop, November 12-16, LaCrosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program Education Services Unit, Mitchell Hall, University of Wisconsin-LaCrosse, LaCrosse, Wisconsin 54601. **Fee** $450.00. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN=3.5 CEUs; Wisconsin Nurses Association, 35 hours; Iowa and Kansas PTs, 35 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** 608-785-8686

Infection Control
Advances in Control of Nosocomial Infection
For: MDs. Conference, November 15-16, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut, St., Madison, WI 53705. **Fee** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Geriatrics
Aging and Illness in Primary Care—4th Symposium On Ethical and Clinical Problems in the Care of the Elderly
For: MDs. Symposium, November 8-9, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee** TBA. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; University of WI-Extension CEU, 13 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Genetic Diseases
Genetic Determined Diseases
For: MDs. Symposium, November 10, 8am-12:30pm, Decatur, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

Medicine & Pathology
Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, November 26, 4:30pm-6:30pm, North Chicago, Illinois. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, Illinois 60064. **Fee** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Allergy
Clinical Allergy for the Practicing Physician
For: MDs. Seminar, November 8-10, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: $250.00. **Reg. Limit:** 150. **Credit:** AAFP Prescribed, 19 hours; AMA Category 1, 19 hours; AOA, 18.5 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

Stress Management
Anxiety and Depression
For: MDs. Symposium, November 29, 2:30pm-7:45pm, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

Teaching Stress Management and Relaxation Skills
For: MDs, RNs, PTs, OTs. Workshop, November 11-15, LaCrosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program Education Services Unit, University of Wisconsin-LaCrosse, Mitchell Hall, Room 221, LaCrosse, WI 54601. **Fee:** $450.00. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEUs; Nurses Assn, 35 hours; Iowa and Kansas, PT, 35 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** 608-785-8686

Surgery
Facial Trauma Conference
For: MDs. Symposium, November 9, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711.

Obstetrics and Gynecology
Infections in Obstetrics and Gynecology
For: MDs. Symposium, November 30-December 1, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D. Asst. Dean for CME. **Phone:** 217-782-7711.

Intensive Care
Trauma Conference
For: MDs. Conference, November 30, 8-5PM, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBD. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

DECEMBER

Internal Medicine
Management of Difficult Arrhythmias
For: MDs. Symposium, December 7, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711.

Advanced Trauma Life Support Providers Course
For: MDs. Workshop, December 13-14, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield 62708. **Fee:** TBD **Reg. Limit:** 16. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711.

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, December 17, 4:30-6:30PM, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** None. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215.

Gynecology
Problem Solving in Gynecologic Endocrinology and Infertility
For: MDs. Course, December 7-8, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago 60637. **Fee:** $250.00. **Reg. Limit:** None. **Credit:** Category 1, 10 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Neurology
The Second Comprehensive Neuroimmunology Conference
For: Neurologists. Course, December 5-8, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago 60637. **Fee:** $300.00. **Reg. Limit:** None. **Credit:** Category 1, 24 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Neurology for the Non-Neurologist
For: MDs. Course Review, December 12-14, The Westin Hotel, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, University Office of Continuing Education, 600 S. Paulina, Chicago 60612. **Fee:** $350.00. **Reg. Limit:** None. **Credit:** AAFP Elective, 20 hrs. **Contact:** Barbara Trejo. **Phone:** 312-942-7119.

Pediatrics
Current Problems in Pediatrics
For: MDs. Lecture, December 3-7, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago 60612. **Fee:** $540.00. **Reg. Limit:** 90. **Credit:** Category 1, 40 hrs., Other: PREP. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600.

Sports Medicine
2nd Annual Hawkeye Sports Medicine Symposium
For: MDs, RNs, PTs, PAs. Symposium, December 6-8, 8-5PM, Iowa City, Iowa. **Sponsor:** The University of Iowa College of Medicine, 285 ML, Iowa City 52242. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBA. **Contact:** Deborah L. Hatz. **Phone:** 319-353-5763.

Cardiology
New Approaches to Management of Profound Congestive Heart Failure. The 4th Annual Conference on Heart Diseases
For: MDs. Lectures, Workshops, December 7-8, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, 465b WARF Bldg., 610 Walnut St., Madison, 53705. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, 10 hrs. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

EKG

(Continued from page 145)

Answers: 1. B, C, D 2. E

The ECG rhythm strip shows atrial fibrillation with a variable ventricular response. There are non-specific ST-T wave changes compatible with digitalis. Our patient had taken digoxin and diuretics since her surgery. The last four R-R cycles in the top ECG strip, the first two and the last two R-R cycles in the middle strip, as well as two in the bottom strip, are all equal. Since atrial fibrillation conducts irregularly through the AV node, these regular R-R cycles with narrow QRS complexes suggest control by the AV junction. These are AV junctional escape beats. If the entire ECG rhythm strip showed the AV junctional rhythm, then digitalis excess or intoxication would be considered.

Intermittent junctional escape beats suggest an adequate but not toxic dose of digoxin. No pacemaker is needed since a decrease in digitalis dose will allow more atrial fibrillation beats to be conducted through the AV node and the ventricular rate will increase. There is nothing to suggest myocardial or pericardial metastases from adenocarcinoma of the colon. The common clinical presentations of metastatic heart disease are pericardial effusion, tachycardias, AV block, and heart failure. Although heart and pericardial metastases have been reported in 1 to 2.8% of cases of carcinoma of the colon, it tends to spread locally. Our patient had long standing atrial fibrillation and no evidence for heart failure. Even though patients with prosthetic cardiac valves receive anticoagulation, this does not preclude general surgery. Anticoagulants can be safely discontinued for the perioperative period. Our own practice is to switch these patients with prosthetic valves from coumadin to heparin anticoagulation for better control in the perioperative period. Our patient underwent a successful hemicolectomy for the carcinoma of the colon.


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AN UPDATE IN PSYCHIATRY

October 29, 1984
3:00 p.m.-9:00 p.m.

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Our Votes Count



In writing about the Leadership Conference last month, I mentioned that, among other things, a physician in the 80's must be a "politician." There are all degrees of political involvement, the very least of which is exercising one's constitutional right to vote.

A key area for physician involvement is in the legislative arena. This is a critical year for Illinois physicians. During its next session, our legislature—both Senate and House—will debate our package of bills concerning professional liability. Malpractice tort reform will command the full attention of ISMS members and staff in the coming months. Notwithstanding all this effort, what happens in Springfield next spring at the end of the session will be decided on November 6th when the State Senators and Representatives who vote on these bills are elected.

Upon being asked what he thought about low voter turnout, Horace Busby, an aide to LBJ, replied, "I've never been disturbed by the low vote. Elections ought to be decided by those who have a stake in the outcome and know what they're doing." We physicians "have a stake" in this election. The opponents of our tort reform feel they "have a stake" as well and you may rest assured they will be out voting. Your participation can and will make a difference. A wise man once said:

> *He who says he is above politics really means he feels democracy is beneath him.*

Let us all make the voice of medicine heard on November 6th. Vote your conscience, but please vote. ◀

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President



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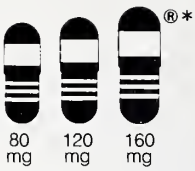


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In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, it necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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MSS Annual Meeting

The sixth annual meeting of the AMA-MSS was held June 15-17, 1984 at the Marriott Hotel in Chicago. Illinois students were active at this meeting, with 18 students in our delegation representing 10 of the 11 medical school campuses in the state. Illinois traditionally has one of the largest and best organized state delegations at MSS national meetings, with student representatives who exhibit the hard work and dedication needed to rise to positions of national leadership. Several resolutions adopted by the MSS assembly were introduced by Illinois students. In addition, an Illinois student, Gail Williamson, was elected to the Governing Council.

MSS Resolutions Sent to AMA House of Delegates

This year, the MSS assembly considered about 30 resolutions and sent nine to the House of Delegates, the official policy-making body of the AMA. Two were adopted outright, and the other seven were referred to the Board of Trustees for further study. None were defeated.

Two of the nine student resolutions sent to the AMA House were introduced by the Illinois delegation. Nancy Zamora (U. of I. Rockford) wrote a resolution, which was adopted, asking the AMA to collect and disseminate to physicians and the public, information about the dangers of ultraviolet light from sun exposure and commercial tanning centers.

Thanks to Alan Scharrer (SIU), the AMA will study communicating with the U.S. Department of Agriculture the AMA's concern about the lack of nutritional guidelines for food stamp recipients, and request that the Federal Food Stamp program be used only for the purchase of nutritionally beneficial foods. Alan was inspired to write his resolution after observing the operation of the WIC (Women, Infants, and Children) program, which successfully uses nutritional requirements as a basis for distributing food items to the needy. His goal is to extend this concept to the food stamp program, which currently lacks effective nutritional guidelines. The AMA will study this issue further and report back at the December meeting with a suggested course of action. (This is an excellent example of how students, with their unique perspectives, can affect public policy by working through the AMA.)

The other student resolution adopted by the House of Delegates asked that the AMA support congressional legislation which would either restore the Student Loan Marketing Association or develop a similar mechanism for consolidation of student loans.

Several student resolutions were referred to the Board of Trustees for study. In one, the MSS asked that the AMA respond to the HHS "Baby Doe" rules, and other similar issues, with an active role in encouraging the development of hospital based multi-disciplinary ethical review committees. Other proposals referred for study dealt with cost containment in medical education, labelling dietary supplements with the toxic side effects of overconsumption and a request for emergency food aid to African nations. Proposals for alcohol counteradvertising and an AMA-sponsored antismoking news supplement were also referred for study.

In addition to those sent to the AMA House, the MSS assembly considered several internal resolutions. Karen Kawala (Rush) introduced one which asks the MSS governing council to study the need for a specialty in geriatrics, and to mon-

(Continued on page 290)

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

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Just once each day for initial therapy in hypertension.

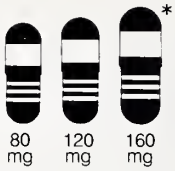
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ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

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Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

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Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
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HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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ISMS Headquarters Office Moves to New Home

As this issue goes to press, relocation of the ISMS headquarters office is nearly complete. Effective October 23, 1984, the ISMS office will occupy the newly renovated atrium building pictured on this month's cover in an illustration by James C. Smith which was commissioned by the developer, U.S. Equities.

The Society and Illinois State Medical Insurance Services will lease the sixth and seventh floors of the new home at Twenty North Michigan Avenue, Chicago. The front pillars of the limestone and granite facade, restored to the original beaux arts style, will identify the structure as the Illinois State Medical Society building.

Relocation to the 41,000 square feet leased by the Society will permit efficient continuation of ISMS and ISMIS activities, and expansion as needed in coming years.

The landmark John M. Smythe building is located just northeast of the 1974-84 headquarters at 55 E. Monroe, Chicago, in the city's central business district. This is the fourth official home for the Society. From 1960 to 1974, the Society's offices were located at 360 N. Michigan, Chicago. Before then, the headquarters office was located in Monmouth.

A lease agreement was negotiated through the Illinois State Medical Inter-Insurance Exchange, permitting sublease of space to the Society and Insurance Services.

The Society entered into negotiation with the developer at an early stage of the renovation. As a result, the Society's unique requirements were integrated in the overall gutting and rehabilitation of the building. The space was designed essentially to specifications at minimal cost.

The architects, Joel Scheckerman and Associates, have provided optimal space for computer services and other essential hardware. A state-of-the-art security system will ensure the safety of the Society's property and personnel. Technologically innovative electrical, heating and lighting systems will ensure energy efficiency and environmental control. A new telephone system will permit direct dial access to most staff members. The general telephone numbers will not change.

ISMS officers and trustees who worked to evaluate and coordinate relocation over the past two years have included Drs. Julian W. Buser, Belleville; Alfred J. Clementi, Arlington Heights; Robert C. Hamilton, Chicago; Alfred J. Kiessel, Decatur; Fredric D. Lake, Evanston; Morgan M. Meyer, Lombard; Warren D. Tuttle, Harrisburg; Fred Z. White, Chillicothe and Cyril C. Wiggishoff, Chicago. ◀

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Other Programs: Adolescent Programs for Eating Disorders, Short Term Diagnostic Evaluation, and Sexual Abuse

For further information about Charter Barclay or admission procedures, contact:

Medical Director: Sanford I. Finkel, M.D.
Hospital Administrator: Edward Goldberg

CHARTER MEDICAL CORPORATION

Obituaries

***Adland, Moris A.,** Peoria, died July 25 at the age of 67. Dr. Adland was a 1939 graduate of the University of Illinois College of Medicine.

***Barnett, George A.,** died July 11. Dr. Barnett was a 1924 graduate of Rush Medical College.

***Baylor, John E.,** Northfield, died June 20 at the age of 67. Dr. Baylor was a 1942 graduate of Northwestern University Medical School.

****Carey, J. Campbell,** Solvang, California (formerly of Joliet) died July 31 at the age of 79. Dr. Carey was a 1928 graduate of Northwestern University Medical School.

***Caviles, Alfredo P.,** Arlington Heights, died July 17 at the age of 47.

***Cooley, William Jr.,** Peoria, died August 5 at the age of 73. Dr. Cooley was a 1936 graduate of Northwestern University Medical School.

****Corcoran, William J.,** Chicago, died July 28 at the age of 91. Dr. Corcoran was a 1917 graduate of Northwestern University Medical School.

***Dorsey, James F.,** River Forest, died September 2 at the age of 71. Dr. Dorsey was a 1942 graduate of the University of Illinois College of Medicine.

***Emerson, Randolph G.,** Mount Zion, died August 11 at the age of 41. Dr. Emerson was a 1968 graduate of the University of California College of Medicine, Irvine.

***Freeman, Wendel R.,** Champaign, died June 14 at the age of 72. Dr. Freeman was a graduate of the University of Illinois Medical School.

***Fulgosi, Berislav A.,** Oak Brook, died July 29 at the age of 62. Dr. Fulgosi was a 1954 graduate of Facultad de Medicina de la Universidad de Madrid, Madrid.

****Gaines, Reuben B.,** Geneva, died July 16 at the age of 79. Dr. Gaines was a 1933 graduate of Rush Medical College.

****Gardner, George H.,** Birmingham, Alabama, (formerly of Chicago) died August 19 at the age of 87. Dr. Gardner was a 1921 graduate of the Johns Hopkins University School of Medicine, Baltimore, Maryland.

****Hirsch, Edwin W.,** Deerfield, died August 16 at the age of 91. Dr. Hirsch was a 1916 graduate of Rush Medical College.

***Hoeffding, Waldemar,** died August 19 at the age of 75. Dr. Hoeffding was a 1936 graduate of Friedrich-Wilhelms-Universitat Medizinische Fakultat, Berlin, Prussia.

***Hoffman, Charles W.,** Joliet, died August 26 at the age of 70. Dr. Hoffman was a 1941 graduate of the University of Illinois College of Medicine.

***Icenogle, Richard E.,** Roseville, died July 17 at the age of 60. Dr. Icenogle was a 1946 graduate of the University of Illinois College of Medicine.

****Immerwahr, Paul,** Chicago, died August 1 at the age of 85. Dr. Immerwahr was a 1924 graduate of Schlesische-Friedrich-Wilhelms-Universitat Medizinische Fakultat, Breslau, Prussia.

***Judson, Glenn L.,** Elmhurst, died July 10 at the age of 69. Dr. Judson was a 1941 graduate of Northwestern University Medical School.

****Kaske, Gordon J.,** Belvidere, died July 10 at the age of 80. Dr. Kaske was a 1930 graduate of the University of Wisconsin Medical School.

****Knudson, Joel W.,** Oak Park, died August 28 at the age of 81. Dr. Knudson was a 1928 graduate of Northwestern University Medical School.

***Maxwell, Mays,** St. Louis, died July 2 at the age of 60. Dr. Maxwell was a 1953 graduate of Meharry Medical College School of Medicine, Nashville, Tennessee.

***Mitchell, Michael F.,** Alton, died August 3 at the age of 64. Dr. Mitchell was a 1947 graduate of the Royal College of Physicians of Ireland and Royal College of Surgeons of Ireland.

***Nisi, Edward,** Westville, died in June at the age of 70. Dr. Nisi was a 1945 graduate of the University of Health Sciences/Chicago Medical School.

***Parrilli, Samuel D.,** Blue Island, died August 28 at the age of 76. Dr. Parrilli was a 1939 graduate of the University of Health Sciences/Chicago Medical School.

****Prock, Francis R., Sr.,** Joliet, died August 19 at the age of 77. Dr. Prock was a 1934 graduate of the Loyola University Stritch School of Medicine.

***Rainey, Clarence W.,** Sarasota, Florida, died January 29 at the age of 89. Dr. Rainey was a 1923 graduate of Rush Medical College.

***Schall, Wayne J.,** Lincoln, died July 29 at the age of 72. Dr. Schall was a 1936 graduate of the University of Nebraska College of Medicine, Omaha. Dr. Schall was a former president and secretary of the Logan County Medical Society.

****Skorodin, Bernard,** Skokie, died August 21 at the age of 85. Dr. Skorodin was a 1931 graduate of the University of Illinois College of Medicine, Chicago.

****Steiner, Matthew,** Evanston, died August 27 at the age of 75. Dr. Steiner was a 1934 graduate of the New York University School of Medicine, New York.

***Sultan, Nathan A.,** Chicago, died April 19 at the age of 67. Dr. Sultan was a 1946 graduate of the University of Health Sciences/Chicago Medical School.

****Tolpin, Samuel,** Chicago, died August 28 at the age of 91. Dr. Tolpin was a 1923 graduate of Rush Medical College.

***Vacante, Anthony B.,** Chicago, died August 23 at the age of 70. Dr. Vacante was a 1939 graduate of the Loyola University Stritch School of Medicine.

**Indicates ISMS member*
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PHYSICIANS

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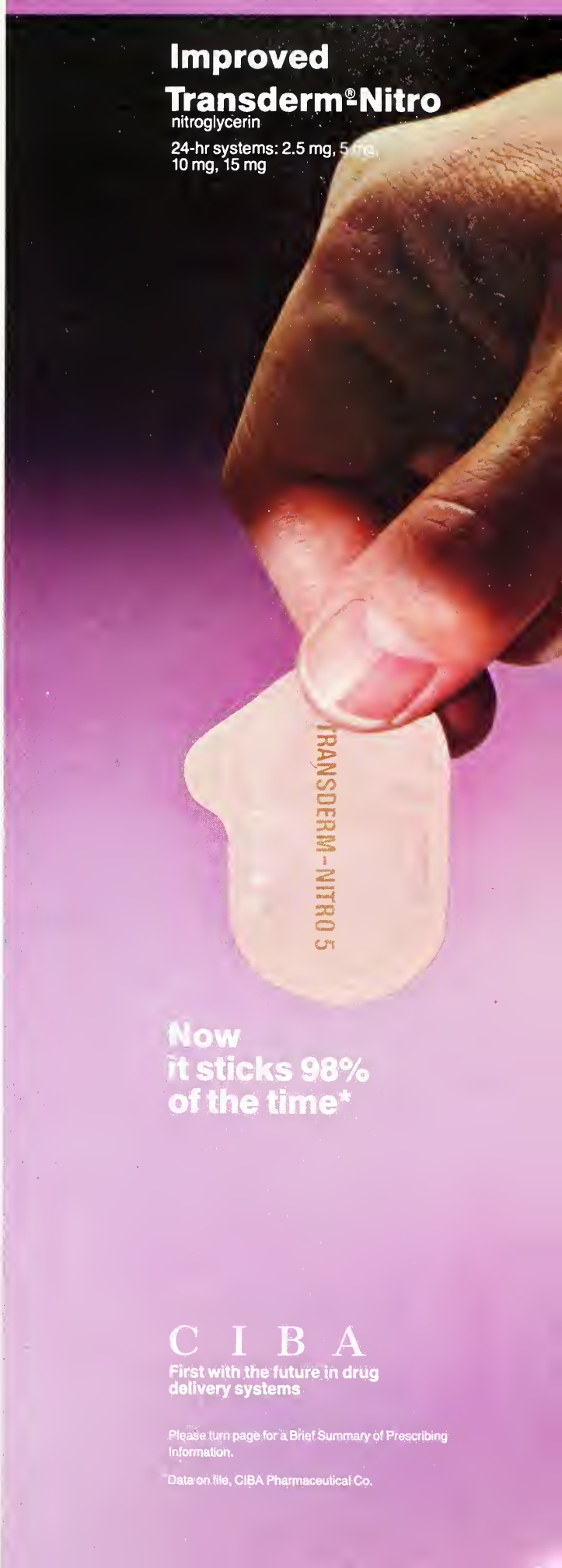
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Transderm®-Nitro

(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)*

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26)
5 mg/24 hr	25 mg	10 cm^2	7 Systems (NDC 0083-2105-07)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26)

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

C84-7 (Rev. 2/84)

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information.)

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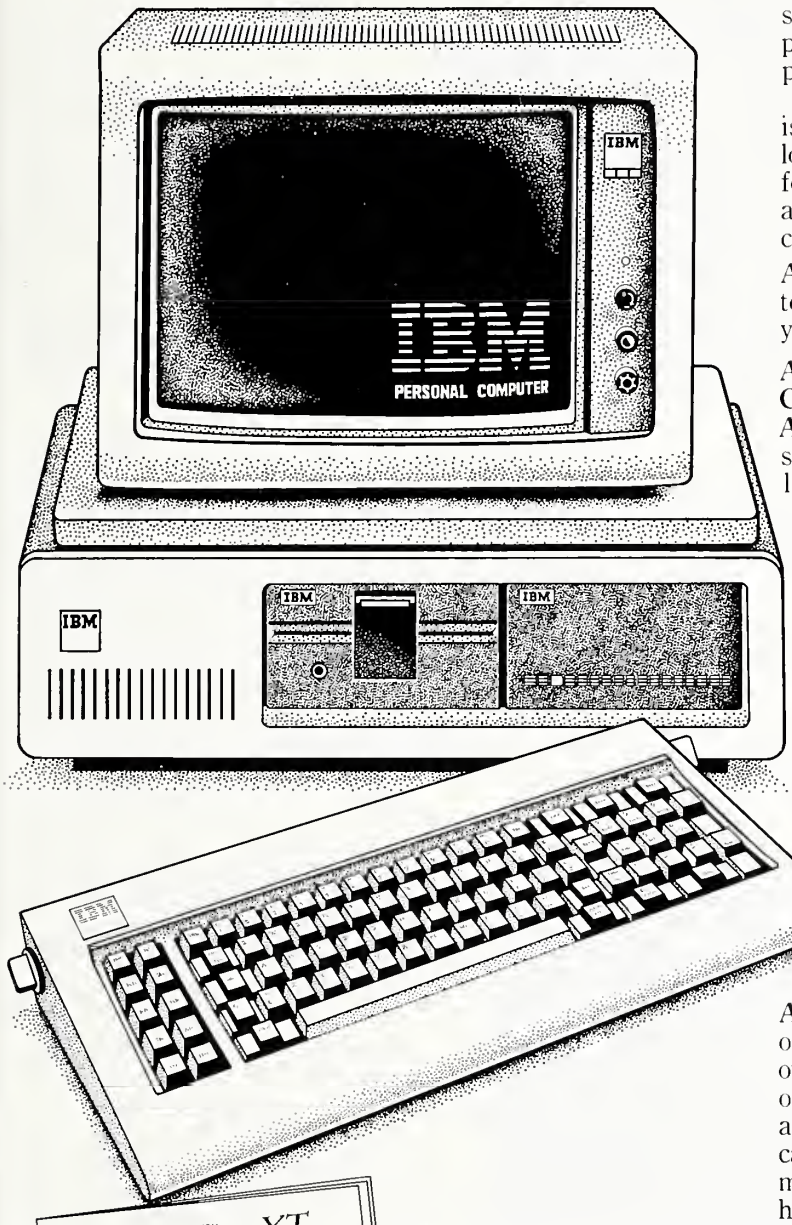
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In Fulton, Missouri

This represents an outstanding medical practice opportunity. County of 30,000 primary service area with fine small community of 12,000+ hosting two nationally known colleges and a growing industrial base. We are close to the Lake of the Ozarks as well as multiple other recreational opportunities and facilities. The hospital has a fine tradition of strong family-practice physicians and has recently recruited an orthopedic surgeon to build its surgical team to two. There are over 400 births in this county each year, and the pediatric population is growing steadily. Residents want the best in specialist medical care. For further information regarding guarantees or other considerations contact Sharon R. Heinlen, Administrator, Callaway Community Hospital, Hospital Drive, Fulton, MO, 65251, 314-642-3376.

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Managing your office shouldn't be hard. It shouldn't be a worry. It shouldn't drain away precious time that you need to spend with your patients. Last, but not least, it shouldn't be costly.

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- Aging account balances.
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A DEPOT. Finally, you need the reassurance of this Wausau symbol. It represents the spirit of small-town helpfulness that backs your state-of-the-art equipment. We train your people and are never further than a "Hot Line" phone call away. We're already helping more than 400 medical offices in 30 states. We'll be happy to help you, too.



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IMJ-10/84

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

BEARDSTOWN:
Family practice with Obstetrics. Join four man group—West Central Illinois—50 bed modern accredited hospital. Salary plus benefits for first two years, leading to opportunity to become equal stock holder. 40 miles from major medical and educational center. Contact: Beardstown Clinic, Beardstown 62618 (217-323-2245).(11)

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309-827-5051). (2)

GLEN ELLYN:
Internist to join large multi-specialty group in western suburbs of Chicago. Attractive salary structure and complete fringe benefit package. Contact: Dave Bauer, Administrator, Glen Ellyn Clinic, SC, 454 Pennsylvania Ave., Glen Ellyn 60137. (11)

GLEN ELLYN:
Progressive five physician OB-GYN department in 60 physician multi-specialty group seeks 6th associate. Attractive location in western Chicago suburbs. Very good family opportunities and professional growth. Excellent hospital facilities backed with strong neonatal program. Contact: Dave Bauer or Joseph Nigro, M.D., Glen Ellyn Clinic, SC, 454 Pennsylvania Ave., Glen Ellyn 60137. (11)

MOUNT CARROLL:
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Today—"I was impressed with AmbuAir's promptness. They made us really feel comfortable," says Richard's mother Carol Engelhaupt.

This is just one of the many cases that tells the story of AmbuAir, a learjet ambulance service on call 24 hours a day in all weather. Even in the most critical situations, you can depend on the trauma trained staff and emergency room equipment on board AmbuAir.

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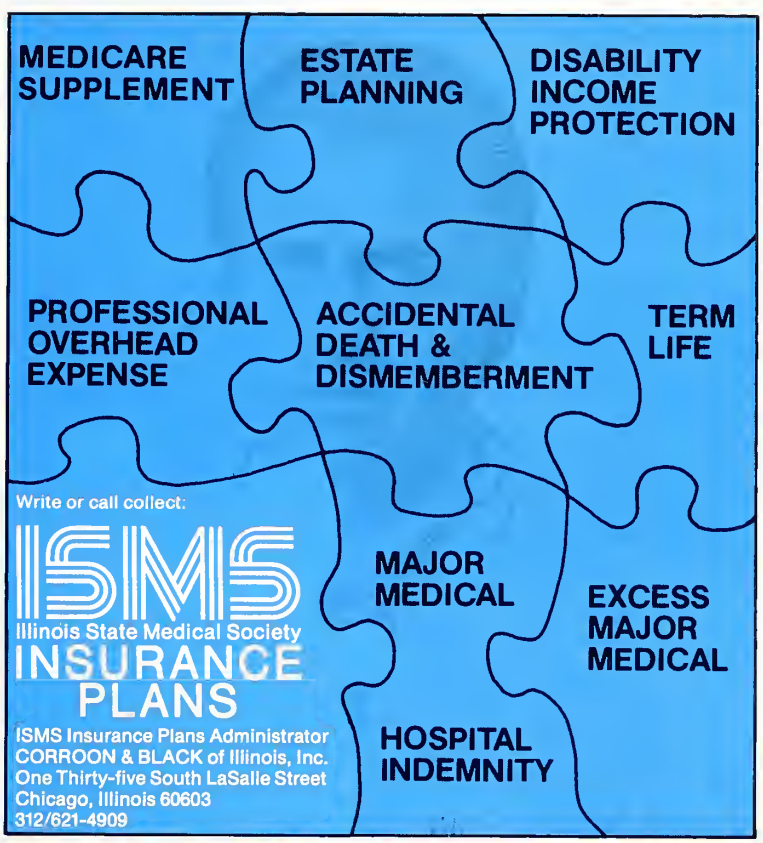
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The Exchange also remains committed to fighting non-meritorious claims against its policyholders at all costs. We simply will not settle frivolous claims. And, unlike some other carriers, we cannot and will not settle any claim without your participation in the decision.

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Overweight and at risk. You know the problems.



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As physicians, every one of us knows the consequences of obesity: cardiovascular disease... diabetes... hypertension... congestive heart failure... an increased risk of sudden death.

Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight—if, in fact, it is ever achieved.

The Institute for Health Maintenance (IHM) can help. Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss: THE RISK FACTOR OBESITY PROGRAM (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised supplemented fast with long-term behavioral and nutritional training.

Under the supervision of the IHM medical staff, patients lose weight safely and consistently over a period of weeks and months. They receive their total daily nutritional requirements from a low-calorie egg albumen formulation and a multivitamin tablet... a supplement they stay with until goal weight is achieved.

The success of the RFO Program has been significant. Over the past five years, thousands of patients have lost from 25 to over 100 pounds, with the average loss being 63 pounds. More important, 75%* of these patients have been able to sustain their new low weight levels with the help of our 18-month maintenance program.

Some have called the RFO Program "life-saving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors—one we at IHM can help control.

To learn more about us and how our program can safely benefit some of your patients, please contact one of our medical directors at a clinic near you.

*Data on file, Institute for Health Maintenance.

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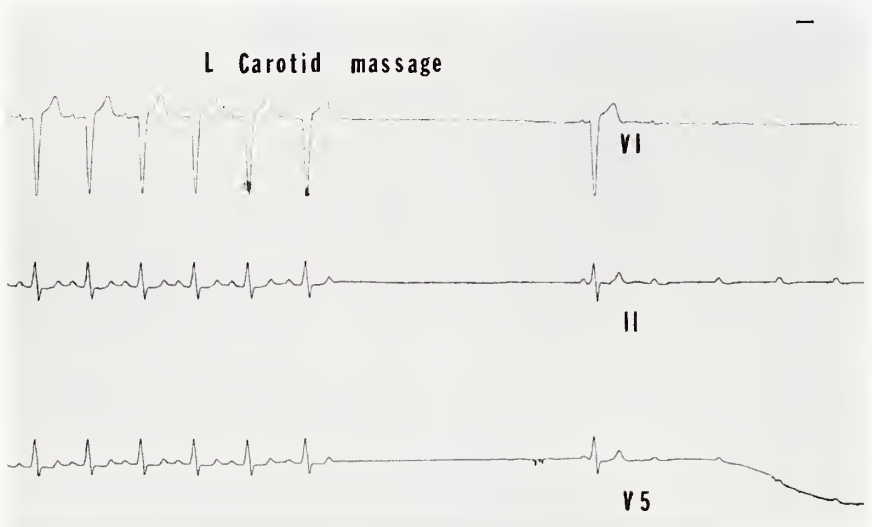
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a sixty-three year old woman who had a history of endometrial carcinoma diagnosed five years earlier. At that time she had undergone a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Now she complained of intermittent weak spells as well as weakness in her legs. At times she felt she would almost black out. Her visit now was prompted by a fainting spell that followed a bout of vigorous coughing. Her physical examination demonstrated a blood pressure of 132/72 and a pulse of 96 beats per minute. Her carotid arteries had normal pulses and no bruits. The lungs were clear. Her heart had an atrial gallop and a grade III/VI crescendo decrescendo systolic murmur. Vaginal examination showed no bleeding. The cervix was surgically removed and no masses were palpable. Rectal exam was normal. Her 12 lead electrocardiogram showed complete left bundle branch block. Right and left sided carotid sinus massages were performed. A three lead rhythm strip with left carotid sinus massage is shown.



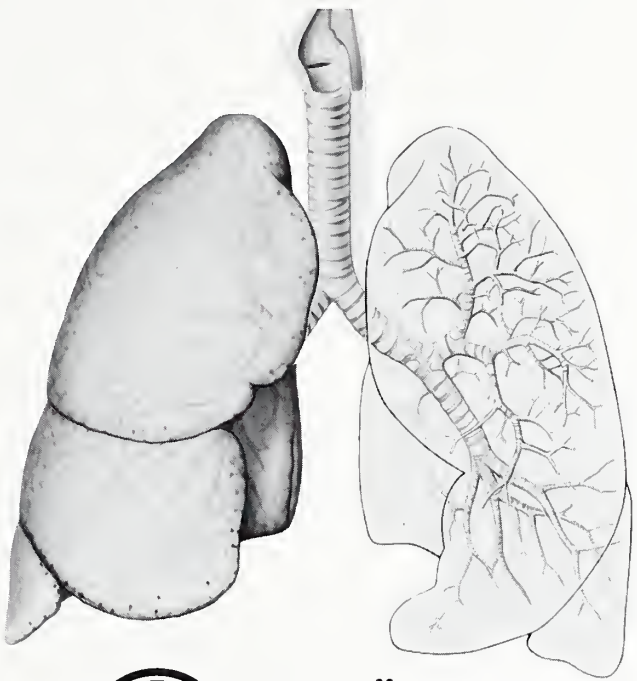
Questions:

1. The leads V_1, II, and V_5 rhythm strip shows:
 a. Sino-atrial block or sinus arrest.
 b. Atrioventricular block.
 c. Junctional escape beat.
 d. An intraventricular conduction defect.
 e. All of the above.

2. The following statement(s) is/are true:
 a. A permanent pacemaker is required.
 b. Digoxin would be helpful.
 c. Quinidine would be helpful.
 d. This ECG suggests metastatic or recurrent carcinoma.
 e. This is a case of hypersensitive carotid sinus syndrome.

(Continued on page 280)

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) **(ampicillin-resistant)**

Brief Summary Consult the package literature for prescribing information

Indications and Usage. Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings. IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions. *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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Additional MRI Information on page 296

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 166, No. 4
October 1984

ISMS Organization

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected to fill the post in May, 1968. He was succeeded by the present executive administrator, Mr. Alexander R. Lerner, in May, 1981. The Society reaches another milestone as this issue goes to press. Effective October, 1984, the headquarters offices relocated to Twenty North Michigan Avenue, Chicago 60602.

The Society published the early transactions in book form, presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. VanDellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established under chairmanship of Dr. J. William Roddick, Jr., to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

ISMS Code of Ethics

WHEREAS, The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient; and

WHEREAS, As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self; therefore be it

RESOLVED, That the following Code of Ethics be adopted by the Illinois State Medical Society not as laws, but standards of conduct which define the essentials of honorable behavior for the physician:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Adopted by the Illinois State Medical Society
House of Delegates
November, 1981

Illinois State Medical Society Constitution and Bylaws

Adopted, 1903
As Amended, 1984

Constitution

Article I. Name

The name and title of this organization shall be the Illinois State Medical Society.

Article II. Purposes of the Society

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Society.

Article IV. Composition of the Society

The Society shall consist of active members and such other members as the Bylaws may provide.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

Article VI. Officers

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

Article VII. Board of Trustees

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

Article VIII. Conventions and Meetings

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

Article IX. The Seal

This Society shall have a common seal with power to break, change or renew the same when necessary.

Article X. Amendments

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. Members. Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. Regular Members. Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. Emeritus Members. Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

C. Retired Members. Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

D. Service Members. Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

E. Distinguished Members. Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

F. In-Training Members. In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

G. Student Members. Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. Discrimination of Membership. Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. Tenure and Termination.

A. Tenure of Membership. The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership so long as he complies with the provisions of this Constitution and Bylaws. A member shall hold only one type of membership at any one time.

B. Termination of Membership. Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES AND ASSESSMENTS

Section 1. Dues. Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal.* Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. Reduction and Remission of

Dues. Regular members may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. Assessments. In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III.
EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. Composition. The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section and 9) one delegate elected by the Medical Student Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. Delegates. Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. Affiliate Group Delegates. There shall be a Resident Physicians Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. Time and Place of Meetings.

A. Annual Meeting. The House of Delegates shall meet in an annual session and may meet in an interim session upon call of the Board of Trustees. The time and place of the annual meeting shall be as the House determines.

B. Interim Meeting. The Board of Trustees may schedule an interim session of the House of Delegates between annual meetings of the House if it determines that there is sufficient, relevant business. An interim meeting of the House should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. An interim meeting should be held in a district other than that of the preceding annual meeting.

Section 5. Quorum. Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. Special Meetings. Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. Registration. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. District Division. The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. Order of Procedure. The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. Privilege of the Floor. The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. Introduction of Resolutions and Other Business. All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters 30 days prior to the annual or interim meeting. Resolutions received after the above date must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. The only business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.
2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.
3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Medical Student Section which are considered urgent and accepted by the Committee on Rules and Order of Business.
4. Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall

require for consideration a two-thirds affirmative vote.

Section 12. Judicial Panel. The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

CHAPTER V. ELECTION OF OFFICERS

Section 1. Officers. The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. Elections. All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. Terms of Office. The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. The President. The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform other duties as custom and parliamentary usage may require. He shall also appoint such task forces as may be needed by the Society.

Section 2. The President-Elect. The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Administrator, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. The Vice Presidents. The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice presidency, the second vice president will become first vice president.

Section 4. Successor to President-Elect. In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. The Speaker. The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. The Vice Speaker. The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. The Secretary-Treasurer. In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom, or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. Delegates and Alternate Delegates to the American Medical Association. Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. Composition. The Board of Trustees shall consist of twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. The Chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member having all privileges except the right to vote. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—DuPage County.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. Duties. The duties of the Board of Trustees are executive and custodial.

A. Executive Duties. The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority. The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.
The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. Custodial Duties. The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board. The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective. Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

Section 3. Executive Administrator. The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. Meetings. The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. Organization.

A. Chairman. The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. Duties of the Chairman. The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.

Section 6. Quorum. Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. County Societies. The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. Publication. The Board of Trustees shall provide and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. Bonding. The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. Duties of Trustees. Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. Vacancies. If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. The Benevolence Fund. Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem appropriate to be held in a fund of a separate incorporated entity known as "The Illinois State Medical Benevolence Fund, Inc." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. Contributions and bequests to the Illinois State Medical Benevolence Fund, Inc., shall be deposited forthwith in said fund.

Section 13. Audit and Financial Statement. The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a

meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Physicians elected to district committees shall serve a three year term of office. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. Committee Structure. The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. Committees Reporting Directly to the Board of Trustees
C. House of Delegates Committees
D. Board of Trustees Committees

Section 2. Councils.

A. The Medical-Legal Council shall be concerned in the areas of:
 1. Liaison with the Illinois Bar Association
 2. Liaison with courts, particularly where impartial medical testimony is involved.
 3. Implementation of the Impartial Medical Testimony Rule
 4. Legal aspects of medical practice other than in the area of mental health
 5. Licensing and standards of practice
 6. Quackery
 7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
 1. Federal and state legislation—analysis and communication
 2. Legislative liaison—both state and federal
 3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
 1. Liaison with medical schools, curricula, etc.
 2. Health manpower and training
 3. Internships, residencies, etc.
 4. Scientific assembly
 5. Student loans
 6. Continuing medical education

D. The Council on Economics shall be concerned in the areas of:
 1. Ongoing relationships with third parties
 2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:
 1. The provision of medical care and health services in the public and private sectors
 2. Emergency medical services
 3. Health care of the poor, aged and those in rural areas
 4. Maternal and child health
 5. Nutrition
 6. Workmen's compensation
 7. Environmental and community health
 8. Rehabilitation
 9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
 1. Publicity and promotion
 2. News media relations
 3. Exhibits and public service programming
 4. Religion and medicine
 5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
 1. Facilities and services
 2. Liaison with Department of Mental Health
 3. Legal aspects of commitment, etc.
 4. Narcotics and dangerous drugs
 5. Alcoholism

H. The Council on Affiliate Societies shall be concerned in the areas of:
 1. Liaison between the affiliate society and ISMS
 2. Scientific resource information and advice to ISMS
 3. Consultation to other councils, *e.g.*, postgraduate education, health care delivery, publicity, legislation
 4. Advances of medical science in special fields
 5. Recommendations to the Board of Trustees on legislative matters affecting any specialty society
 6. Affiliate Societies
 a. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
 1. as may be approved by the Board of Trustees
 2. which desire representation on the Council on Affiliate Societies
 b. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 3. Organization of Councils.

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Medical Student Section and resident physician members nominated by the Governing Council of the ISMS Resident Physicians Section may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

 Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

 A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils and task forces, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

 Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

 The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

 All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

Section 4. Task Forces. A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of

Trustees, shall be appointed by the President upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.

Section 5. Committees Reporting Directly to the Board of Trustees

A. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as chairman of the committee.

B. Committee on Insurance. This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.

C. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain liaison with various organizations as determined by the Board of Trustees.

D. Committee on Drugs and Therapeutics. The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

E. Health Data Committee. The Committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.
The committee shall be knowledgeable of the workings of various organizations as determined by the Board of Trustees.

F. Peer Review Appeals Committee. This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to local peer review committees and monitors activities around the state.

G. Committee on CME Accreditation. It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

H. Committee on Hospital Medical Staffs. The committee shall address the concerns of and develop programs for ISMS members as physicians on hospital medical staffs in their association with the administration and governing boards of hospitals. The committee shall keep abreast of developments in hospital-medical staff relationships; monitor and work with the AMA Hospital Medical Staff Section and ongoing efforts organized by component medical societies; and to the extent feasible, provide informal liaison with organizations impacting on Illinois hospital medical staffs.

Section 6. House of Delegates Committees. House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.
It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.

C. Committee on Tellers and Sergeants-at-Arms shall:
1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 7. Organization of House of Delegates Committees.

A. Immediately after the organization of the House of Delegates at each meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.
Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 8. Board of Trustees Committees. The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio

members of the Executive Committee without vote. The chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society. This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence program to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

G. CME Accreditation Appeal Panel. The panel will consist of seven trustees. It will function as a hearing committee when a CME sponsor appeals a decision of the CME Accreditation Committee. The hearing shall be conducted in conformance with written procedures adopted by the Board of Trustees.

H. The Building and Capital Equipment Committee shall consist of the Chairman of the Board, the President, the President-Elect, the Secretary-Treasurer, the Chairman of the Finance Committee, and the Immediate Past Chairman of the Board, provided that person is a Trustee.

I. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 9. Powers of the Board of Trustees. The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 10. Term of Membership. The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws of ISMS and the constituent society.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving his application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed neces-

sary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. Members of the Illinois State Medical Society shall be bound by the Constitution and Bylaws of ISMS.

CHAPTER XI. ETHICAL RELATIONS

Part 1. Component Medical Society. Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings.*

Part 2. District Ethical Relations Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee serving its area function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relation Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

Part 3. Offenses.

A. Disciplinary action may be taken against any member of a component society when:
 1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
 2. He has been adjudged or otherwise recorded as guilty by his component society of:
 a. acts of serious misconduct as a physician; or
 b. a violation of the Constitution or Bylaws of his component society, or of the code of Medical Ethics promulgated by the Illinois State Medical Society; or
 3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

Part 4. Standards and Procedures.

A. The committee, in its deliberations, shall evaluate acts by the standards established in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.

B. Disciplinary action may be initiated by the component society or the ISMS upon receipt of formal written charges filed by any person, alleging violations of any of the offenses enumerated in Part 3 of this chapter. The person filing the complaint may submit it to either the county where the accused physician holds membership or the county where the alleged incident occurred.

 Written charges received by the Illinois State Medical Society shall be referred to the secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

Part 5. Penalties. The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) months period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to this expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

Part 6. Decision by Component Medical Society.

A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description of these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.

B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

Part 7. Judicial Panel. A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or inpact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to

physicians accused of violations of provisions of these bylaws.

A notice of appeal shall be filed with the ISMS Judicial Panel by one of the parties within 30 days after receiving notice of a decision from the component society. Within 15 days after the required filing date for appeal, the party requesting the appeal shall file a written statement with the Judicial Panel which shall include a description of the errors believed to have occurred during the prior proceedings or assertations of the substantive grounds for requesting the Appellate Hearing.

A party may be granted an appeal hearing if: 1) There is reason to believe that procedural error(s) ocurred which significantly affected the outcome of the case; 2) There is a showing that those who conducted the initial hearing acted with bias; 3) The evidence upon which the decision was based was not sufficient to support the decision; 4) The evidence was not properly received or considered; or 5) In the sole discretion of the Judicial Panel, there were other reasons which adversely governed the proceedings and denied due process rights to the party requesting the appeal.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an initial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws.

In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees. The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings,* to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

Part 8. Due Process Safeguards. In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

CHAPTER XII PEER REVIEW

Part 1. Definitions. Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted by the county society where the physician holds membership or where the incident which served as the basis for the peer review complaint occurred. Ethical relations issues identified during deliberations of the county peer review committee, or where appropriate, the District Peer Review Committee may be referred to either the county or district ethical relations committee, as deemed appropriate by the county (district) committee.

Should an adverse decision be made against a physician by a county society where the reviewed practitioner does not hold membership, that decision will have the weight and effect of a decision made by his own county society. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

Part 2. Component Society Procedures.

A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.

B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.

C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.

D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review certain local proceedings of the component society or district committee. A petition for an appeal must set forth one of the following grounds as a basis for the appeal:

1. PROCEDURAL ERROR—The peer review proceeding was not conducted in accordance with written rules established by the component society, district committee, or the Illinois State Medical Society.

2. BIAS—The proceeding was conducted in a biased or arbitrary manner.
3. INCOMPLETE INFORMATION—If information not available to the component society or district committee is submitted to the State Peer Review Appeals Committee, the committee will first determine the relevancy of the new information. The case will be referred to the component society or district committee for reconsideration if the information is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

Part 3. District Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

Part 4. Illinois State Medical Society Procedures.

A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

The Peer Review Appeals Committee shall review appeals of decisions of component or district peer review committees in accordance with the provisions of Part 2 (D) of this chapter. The state committee shall determine the validity of the alleged grounds and, if found valid, remand the case to the local or district committee for a rehearing. If the alleged grounds are found invalid, the decision of the district or county committee shall be deemed to be reaffirmed. The decision of the Peer Review Appeals Committee shall be forwarded first to the county or district committee and then to the appellant. The state committee shall have authority to assign cases to district peer review committees in accordance with Part 3 of this chapter. Decisions of the state committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.
C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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1984-1985

Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."
"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, AMA delegates and alternate delegates, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

Established policy must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

Professional Policies

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement.
(Amended, 1980 Annual Meeting)

Abuse and Neglect of the Elderly

Physicians, nurses and other health care personnel are reminded to be aware of possible instances of abuse and neglect of the elderly and are encouraged to report suspected cases appropriately.
(1982 Annual Meeting)

Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists.
(1975 Annual Meeting—Reviewed by Board 1980)

Advertising Guidelines, Physician Professional

In keeping with the Principles of Medical Ethics, as well as rules of law, the following advertising guidelines are adopted:

I. General
These guidelines shall apply to solo practitioners and groups of physicians, including medical clinics, HMOs, and other physician-operated facilities. The medical society recommends that these guidelines be suggested for hospitals and other health care institutions. The medical society does not look with favor upon advertisements which promote or produce unfair competition.

II. Acceptable Professional Identification
1. Name, with earned degree(s)
2. Office address and telephone
3. Home address and telephone
4. Answering service
5. Office hours

6. Medical specialization
7. Board certification
8. Type of practice (group, solo) and affiliation, so long as such identification is not misleading
9. Hospital affiliation
10. Foreign language competence
11. Usual and customary fees, for routine medical service. Such fee identification must include notification that fees may be adjusted in the event that complications or unforseen circumstances arise. The usual and customary fee quoted shall be that fee charged to the majority of patients seeking the same basic service. Such fee identification must not be misleading. Average charges may not be stated.
12. Public announcement of changes in any of the above

III. Professionally Unacceptable
1. Testimonials or anecdotal reports of medical practice success
2. Claims of superior quality of care
3. Fee comparisons of available services with those of other licensed physicians or medical clinics
4. Listing of professional service which the offerer is not qualified to provide
5. Statements which contain false, fraudulent, deceptive or misleading material
6. Warranties or guarantees of success or unsuccessful therapy
7. Statements which play upon the fears and vanities of the public
8. Display or similar advertising that may serve to mislead or misinform the public
9. Solicitation of media coverage of medical services by means of "news stories" designed for personal or financial gain

IV. Media Guidelines
1. Newspapers and magazines
 a. Type size shall be that text type used in the publication
 b. Use of any ornaments, embellishments, or symbols is prohibited
2. Professional or business cards, and office signs giving allowable information are permissible
3. Health care services directories (including telephone directories) are subject to the same policies as stated under newspapers and magazines above

(1979 Annual Meeting)

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity, by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics.
(Amended, 1980 Annual Meeting)

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socioeconomic impacts, should be encouraged.
(Amended, 1980 Annual Meeting)

Ambulance Services

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards.
(Amended, 1980 Annual Meeting)

Anaphylactic Reactions to Insect Stings

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.
(1981 Annual Meeting)

Animals in Research and Education

The Illinois State Medical Society endorses the position that research and medical education, which involves the use of animals, is necessary to enhance the medical care of the public.
(1983 Annual Meeting)

Assessments

Medical staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds on other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments.
(Amended, 1980 Annual Meeting)

Athletic Programs

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment.
(Amended 1980 Interim Meeting)

Audits and Surveys

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additional, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned.
(Amended, 1980 Interim Meeting)

Autopsies

Because the autopsy has public health and educational benefits for medical science, the family of the decreased individual and the public at large, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.
(Amended 1984 Annual Meeting)

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.
(Reviewed, 1980)

Blood Availability

The Illinois State Medical Society encourages component societies to support abolition of blood bank replacement deposit fees (often referred to as penalty or non-replacement fees).

The Illinois State Medical Society and its component societies encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.
(1979 Annual Meeting)

Blood Services

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county.

The Illinois State Medical Society will attempt to educate physicians and their patients through its publications regarding the inability of contracting AIDS by donated blood. "Designated blood donations" are an inappropriate means of dealing with the AIDS problem and inordinately tie up blood supplies.
(Amended, 1984 Annual Meeting)

Cardiopulmonary Resuscitation

ISMS encourages basic cardiac life support training in Illinois high schools.
(1981 Annual Meeting)

CPR and First Aid Training for Health Club Employees, Mandatory

ISMS endorses the concept that persons responsible for monitoring or instructing others in health and fitness facilities be certified in basic cardiopulmonary resuscitation.
(1984 Annual Meeting)

Child Abuse

ISMS urges all state health agencies and family service agencies which become involved in child abuse cases, to conduct, promptly, necessary investigation of the family environment prior to the release of the child for return to the same home where the abuse occurred.
(1981 Interim Meeting)

Child Safety Restraints

ISMS supports and encourages public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourages physicians and others to discuss their benefits with all parents. Physicians are encouraged to learn about important safety features which have proven effective.
(1981 Interim Meeting)

Chronic Care Patients

The Illinois State Medical Society encourages medical schools and residency training programs to develop curricula addressing the issues of utilization of community resources and the strategies for dealing with the long-term medical, rehabilitation and social needs of chronic care patients.
(1984 Annual Meeting)

Code of Ethics

The following Code of Ethics represents standards of conduct defining the essentials of honorable behavior for the physician. They are not laws.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

(1981 Interim Meeting)

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness. Section IV of the Principles of Medical Ethics states that: "A physician shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient relationship by officials and personnel of review organizations and will take whatever steps necessary to eliminate the breach of confidence.

ISMS is in opposition to the use of the Social Security number as a universal number identifier.
(Reviewed, 1981)

Continuing Education

The Illinois State Medical Society continues its strong support of voluntary continuing medical education in Illinois and the intrastate accreditation of quality CME programs as continuing education is one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multifaceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have a primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities.

Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

Financial support for the Illinois Council on Continuing Medical Education is provided by the Board of Trustees of ISMS. ICCME shall prepare an annual financial report for the House of Delegates including (a) major sources of income; (b) major categories of expenditure and (c) a proposed budget for the year in which the House is meeting.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.
(Amended, 1984 Annual Meeting)

Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a non-proven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services, should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.
(Amended, 1983 Annual Meeting)

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.
(1977 Annual Meeting)

Death, Legal Definition of

A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an indi-

vidual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.
(Amended, 1981 Interim Meeting)

Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based upon what must necessarily be a private matter between physician and patient. If passage of such legislation is imminent, it must provide immunity from civil and criminal penalties for physicians who act in good faith and in accordance with accepted medical practice and must not require physicians to act in violation of their own personal beliefs, morals and conscience.
(Amended, 1981 Annual Meeting)

Diagnosis Related Groups

ISMS supports the concept that the individual hospital medical staffs' responsibility is to ensure that appropriate quality of care for patients shall not be compromised in the Diagnosis Related Groups (DRG) process.
(1983 Annual Meeting)

DRG Payments and Cost of Procedures

ISMS encourages hospitals to establish a mechanism whereby physicians will have ready access, upon admission of patients, to information about expected DRG payments and charges for hospital procedures.
(1984 Annual Meeting)

Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.
(Amended, 1980 Annual Meeting)

Drinking Age, Legal

A uniform national legal drinking age of 21 years should be established by all states.
(1984 Annual Meeting)

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Only those generic drugs which are actually bio-equivalent should be included in the Illinois Formulary for the Drug Product Selection Program of the Illinois Department of Public Health.

ISMS urges IDPH to monitor and enforce proper generic drug substitution by pharmacists according to bio-equivalency based on the formulary.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.
(Amended, 1982 Annual Meeting)

Drunk Drivers

ISMS supports laws providing for stiffer sentencing of drunk drivers and encourages the judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol.
(1981 Interim Meeting)

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.
(1976 Annual Meeting—Reviewed by Board, 1981)

Emergency Medical Care, Provision of

Emergency care should be provided regardless of the ability of the patient to pay. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

The Illinois State Medical Society encourages the State of Illinois and the business community to provide an emergency medical kit and qualified individuals for the administration of appropriate emergency care at functions where a very large number of individuals are present.

Insurance plans which cover emergency medical services should pay for such services regardless of where they are rendered.
(Amended, 1983 Annual Meeting)

Ethics

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.
(1979 Interim Meeting)

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.
(1966 Annual Meeting—Reviewed by Board, 1980)

Experimental Medical Procedures

With respect to experimental medical procedures, physicians must adhere to and affirm the following:

Accepted ethical standards;

The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;

Appropriate Illinois statutory or regulatory requirements.
(Amended, 1981 Annual Meeting)

Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS vigorously opposes any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.
(1976 Annual Meeting—Reviewed by Board, 1980)

Fees, Informing Patients of

Where feasible and desirable, physicians should provide patients with information regarding fees and, where practicable, discuss this information prior to providing care.
(1984 Annual Meeting)

55 M.P.H. Speed Limit

The Illinois State Medical Society opposes an increase in the 55 mile per hour speed limit.
(1981 Annual Meeting)

Firearms

The Illinois State Medical Society supports the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition. It opposes any state legislation in Illinois that would prohibit the enactment or enforcement of county or municipal ordinances restricting the ownership, purchase, sale, transport or transfer of firearms or firearm ammunition.
(1982 Annual Meeting)

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economi-

cally feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a state-wide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.
(1977 Interim Meeting)

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.
(1976 Interim Meeting—Reviewed by Board, 1981)

Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.
(1978 Annual Meeting)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.
(1977 Interim Meeting)

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.
(1967 Annual Meeting—Reviewed by Board, 1980)

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.
(Amended, 1979 Interim Meeting)

Health Insurance, Voluntary Plans

ISMS supports private, voluntary catastrophic health insurance, including freedom of choice of physician. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for ambulatory diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

When insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed. If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do. Under such circumstances, recouping of the money from the patient should be the responsibility of the insurance company, or its agent, that committed the error and not the responsibility of the physician.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physician's charges above insurance benefit allowances are excessive;
- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;
- Suggesting that physicians perform alternative surgical procedures;
- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;
- Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and
- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1982 Annual Meeting)

Health Maintenance Organizations

Every insurance identification card for a health maintenance organization should have the designation, "HMO," clearly printed on the front of the insurance card, along with the warning that unauthorized services may not be reimbursed and along with a 24-hour telephone number which can be called for payment approval in the event of an emergency.
(1982 Interim Meeting)

Health Planning

ISMS supports health planning on a local and voluntary basis with input by a significant number of physicians licensed to practice medicine in all its branches. Planning and implementation of the plan (regulation) are two different processes and should be kept separate and distinct.
(Amended, 1982 Annual Meeting)

Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.
(1974 Annual Meeting—Reviewed by Board, 1980)

Health Systems Agencies

The Illinois State Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim measure, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with federal SHPDA designated criteria.
(1981 Annual Meeting)

HSA Fund Solicitation

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.
(1980 Annual Meeting)

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.
(1977 Annual Meeting—Reviewed by Board, 1984)

Hospices

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either in-patient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.
(1981 Annual Meeting)

Hospital and Medical Staff Committees

A hospital's medical staff should be an autonomous, self-governing body whose members participate in the activities of medical staff and hospital committees. However, physicians should distinguish between committees where the hospital gives the staff authority and responsibility and those where the hospital has full responsibility. Medical staff committees should be those composed solely of members of the medical staff and concerned with the quality of medical care. Hospital committees should be viewed as those created for some general hospital function and composed mainly of hospital personnel, that may or may not include medical staff members.
(1982 Interim Meeting)

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. The hospital medical staff and only the medical staff should establish minimum limits of professional liability insurance coverage for their own medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on the medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of the hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.
(Amended, 1982 Interim Meeting)

Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society supports physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients.
(1980 Annual Meeting)

IDPA Drug Manual

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will continue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bioequivalence.
(1981 Annual Meeting)

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed by the local or state medical society.

ISMS continues to support the need for physical examinations of, and updating of immunizations for school children in the State of Illinois on school entry, at 5th grade and 9th grade levels, in keeping with preventive medicine measures presently in existence in the state. Measures to assure compliance of the school health mandates by school districts in Illinois should be maintained.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.
(Amended, 1984 Annual Meeting)

Indigent, The Care of the

The Illinois State Medical Society reaffirms organized medicine's commitment to provide care to those who need medical care, regardless of their ability to pay for it.

However, personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.
(Amended, 1982 Interim Meeting)

Infants Born with Disabilities, Care and Treatment of

The Illinois State Medical Society urges all Illinois medical staffs to develop and conduct educational programs for their members involved in the care of handicapped infants, regarding advances in such care, as well as laws and regulations affecting the delivery of these infants.
(1984 Annual Meeting)

Informed Consent

ISMS endorses the position that disclosures made to patients conform to the general practices of the medical profession in the same or a similar community or locality, which are disclosures that a reasonable medical practitioner would make under the same or similar circumstances.

ISMS opposes legislative definition of informed consent.

However, it favors enactment of legislation providing that consent for furnishing medical treatment to an adult patient, who is not capable of consenting, may be given or refused by the patient's competent spouse, parent, adult child or adult sibling.
(Amended, 1982 Interim Meeting)

Joint Commission on Accreditation of Hospitals

A "physician" (doctors of medicine or doctors of osteopathy) is defined as one who by education, training, experience, and licensure is able to practice medicine in all of its branches. ISMS encourages the Joint Commission on Accreditation of Hospitals to require greater than a majority of fully licensed physician membership on the medical staff executive committees in acute care general hospitals. ISMS urges JCAH to recognize the importance of the medical staff in credentialing and in monitoring the quality of care in the hospital and it encourages the development of the appropriate environment within the hospital so that both the medical staff and limited licensed practitioners may work together for the best interests of the patient.
(1983 Annual Meeting)

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches.
(Amended, 1980 Interim Meeting)

Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered a surgical procedure.
(1981 Annual Meeting)

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.
(1976 Annual Meeting—Reviewed by Board, 1980)

Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.
(Amended, 1980 Annual Meeting)

Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

It favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

It supports the philosophy that all medical education accepted for licensure to practice should be comparable.

Graduates of state medical schools are encouraged to practice medicine in Illinois and ISMS will utilize its organizational structure to develop positive incentives.

ISMS encourages primary care residency programs to establish educational activities in the rural and underserved areas of Illinois.
(Amended, 1982 Interim Meeting)

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coroner system, wherever practical.
(1971 Annual Meeting—Reviewed by Board, 1980)

Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.
(1979 Annual Meeting)

Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

Unless physicians appointed to the boards and committees of other organizations are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

ISMS supports the concept that when federal funds are available to the states, physicians should actively participate in the distribution of these funds.
(Amended, 1982 Interim Meeting)

Medical Staff Participation in Accreditation Activities

Medical staff of a hospital should cooperate to achieve JCAH accreditation of their hospital.
(1982 Interim Meeting)

Medical Staff Participation in Hospital Cost Containment Efforts

Physicians on a hospital's medical staff should encourage and cooperate in efforts to see that hospital care is delivered in the most effective manner without compromising quality.
(1982 Interim Meeting)

Medical Staff Relationship with County Medical Society

County medical societies are encouraged to form standing committees composed of medical society officers and representatives of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations and official and voluntary health related agencies in their community.
(1982 Interim Meeting)

Medical Supplies, In-Flight

The Illinois State Medical Society encourages air carriers to equip planes with an emergency kit on each flight and that flight crews be instructed in cardio-pulmonary resuscitation procedures.
(1982 Interim Meeting)

Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness, must satisfy the definition of an expert witness that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physi-

cian appearing as an expert witness who does not meet this standard.
(1977 Annual Meeting, Reviewed by Board, 1981)

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.
(Amended, 1980 Annual Meeting)

Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.
(1980 Interim Meeting)

Mental Health

The Illinois State Medical Society strongly opposes a double standard of care in state hospitals.

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available areawide.

All physician or other health service provided to the DMHDD, other than that by fulltime employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches and a physician licensed to practice medicine in all of its branches should be required to certify the discharge of any patient from a psychiatric institution.
(1977 Annual Meeting—Reviewed by Board, 1981)

Motorcycle Helmets

All Illinois physicians should encourage their patients who use motorcycles to wear protective helmets, pointing out the efficacy of such helmets in preventing death during collisions.
(1982 Annual Meeting)

Multiphasic Screening

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the State of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities.
(Amended, 1980 Interim Meeting)

Newborns, Prenatal Development of

The public concern about the macroenvironment's effects on human health should be expanded to include equal concern for a healthy intrauterine environment for the prenatal period of development of each child.
(1984 Annual Meeting)

Nurses-Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.
(1970 Annual Meeting—Reviewed by Board, 1980)

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.
(1973 Annual Meeting—Reviewed by Board, 1980)

Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.
(Amended, 1980 Annual Meeting)

Occupational Health

Occupational health is an essential ingredient of employee welfare. The continued adoption and development of occupational health programs in the private and public sectors should be encouraged.
(Amended, 1980 Interim Meeting)

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.
(1978 Annual Meeting—Reviewed by Board, 1984)

Patient Care Records and Their Availability

Patient care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in case of psychiatric illness. In the case of nonhospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient, a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs to accomplish scientific review, peer review or other patient care improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees. ISMS will take all appropriate action to preserve the confidentiality of records and activities of medical staff committees.

Pursuant to a subpoena for records, a physician is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released, a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made.

Reference may be made 1979, Illinois Revised Statutes, Chapter 48, Section 138.8; Chapter 51, Sections 71, 73 and 101; Chapter 91½, Section 800ff.
(Amended, 1984 Annual Meeting)

Peer Review

See Chapter XII of the Bylaws.
(Amended, 1983 Annual Meeting)

Physician-Patient Relationship

The Illinois State Medical Society encourages voluntary health organizations to work with the available local medical communities in providing referral and treatment of cancer

patients so that existing physician-patient relationships are not breached.
(1984 Annual Meeting)

Physician Records, Privacy of

The Illinois State Medical Society will take appropriate action to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.
(Amended, 1984 Annual Meeting)

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches."
(Amended, 1981 Interim Meeting)

Physician's Assistants

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.
(1980 Annual Meeting)

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.
(1976 Annual Meeting—Reviewed by Board, 1984)

Provider Organizations, Exclusive

ISMS should monitor the development of health maintainance organizations, IPAs, preferred provider organizations, and exclusive provider organizations in Illinois and have this information available to assist ISMS members in their relationships with these organizations.
(1984 Annual Meeting)

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.
(1975 Annual Meeting—Reviewed by Board, 1980)

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multispecialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multispecialty care for Public Aid patients should be made available without extensive justification procedures.
(Amended, 1981 Interim Meeting)

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.
(Amended, 1980 Annual Meeting)

Rehabilitation

All physical rehabilitation activites should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.
(Prior to 1965—Reviewed by Board, 1980)

Reimbursement of Ambulatory Services

Third party payors should be encouraged to provide coverage for ambulatory surgery and diagnostic procedures. Final medical decisions must remain in the hands of the attending physician. However, the Illinois State Medical Society supports the concept of maximum utilization of ambulatory surgical services consistent with the doctor's judgment of the facilities available.
(Amended, 1982 Annual Meeting)

Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.
(1980 Annual Meeting)

Reimbursement for Out-Patient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.
(1980 Annual Meeting)

Reimbursement for Treating Medicaid Patients

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients.
(1981 Annual Meeting)

Reimbursement, Physician

In order to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician's right to choose which method of economic reimbursement for care that best suits the needs of that physician and his/her patients. Where appropriate, ISMS supports the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays. To the extent practicable, ISMS should strive to assist physicians in understanding alternative reimbursement systems.
(1984 Annual Meeting)

Relationship with Third Party Payors

ISMS should provide guidance, education, communications, and negotiations between the membership and third party payors.
(1980 Annual Meeting)

Seatbelt Use

The Illinois State Medical Society supports the voluntary use of seatbelts and other passenger restraint devices as effective meth-

ods of reducing injury and death in motor vehicle accidents. It supports state legislation requiring that all school buses be equipped with passenger safety restraints and other structural modifications to assure maximum impact safety.
(Amended, 1983 Annual Meeting)

Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

Physicians and their employees should refrain from smoking during patient contacts.

Physicians should give advice and provide literature and signs concerning the health hazards of smoking.

ISMS encourages and supports efforts, legislative and otherwise, to ban or restrict smoking in all public places and the development of appropriate regulations to accomplish this. It will work collaboratively with other agencies to advocate publicly a vigorous stand that cigarette smoking is a major known health hazard and a remedial factor in the high cost of health care.
(Amended, 1984 Annual Meeting)

Surgery, Reconstructive

Surgery to correct post-surgical deformities is reconstructive surgery.
(1979 Annual Meeting)

Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.
(1979 Annual Meeting)

Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization over and above the judgment of the treating physician.
(1978 Annual Meeting)

Tobacco Farm Subsidies

The Illinois State Medical Society opposes the subsidization or price supports of tobacco farming.
(1982 Annual Meeting)

Usual and Customary or Reasonable Reimbursement

The Illinois State Medical Society endorses the AMA policy on physician reimbursement, which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule.
(1979 Annual Meeting)

Veterans Administration

The Illinois State Medical Society continues to support the concept that a Veterans Administration hospital should only be concerned with the needs of those patients with service-connected disabilities.
(Amended, 1980 Annual Meeting)

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.
(1978 Annual Meeting)

Workers Compensation

The Illinois State Medical Society advocates a single radiologic examination to satisfy the medical requirements at a given time in the course of a workers compensation injury.
(1982 Annual Meeting)

ADMINISTRATIVE POLICIES

AMA-ERF

The AMA-ERF contributions for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by advising ISMS in writing.
(Amended, 1980 Interim Meeting)

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society.
(Amended, 1980 Interim Meeting)

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.
(1978 Interim Meeting)

Councils and Committees

It is the policy of the Board of Trustees to encourage evening or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.
(1981 Annual Meeting)

Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Department of Registration and Education to the appropriate county society.
(1980 Interim Meeting)

Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or

levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates.
(1980 Annual Meeting)

Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates. (Amended, 1980 Annual Meeting)

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for elections as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.
(1977 Annual Meeting)

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.
(1978 Annual Meeting)

Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.
(1981 Annual Meeting)

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.
(Prior to 1965—Reviewed by Board, 1980)

Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal;*
2. Brief notice in Action Report, whenever possible, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(Amended, 1982 Annual Meeting)

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.
(Prior to 1965—Reviewed by Board, 1980)

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils or major committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except when emergency action is necessary because of unexpected vacancies.

Nomination for appointments to subcommittees, ad hoc committees, other minor committees of AMA or as AMA representatives to certain outside agencies may be made directly by the Chairman of the ISMS Board of Trustees, after consultation with the Chairman of the ISMS Delegation, without specific approval of the full Board of Trustees or AMA Delegation. Such action shall be reported to the Board of Trustees and the AMA Delegation.

Upon receiving notice that an Illinois physician has been nominated for AMA position by an organization other than ISMS, the Chairman of the ISMS Board of Trustees, pursuant to the recommendation of the Chairman of the AMA Delegation, shall inform AMA only whether or not the nominee is a member in good standing of ISMS.
(Amended, 1981 Interim Meeting)

Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Board of Trustees.
(Amended, 1980 Annual Meeting)

Legislation

All matters presented to the House of Delegates or Board of Trustees pertaining to state or federal legislation shall be reviewed by the Governmental Affairs Council, which shall evaluate its potential impact on the society's current legislative efforts. The council shall submit its report to the Board of Trustees, which shall advise and recommend action to the House through the Chairman of the Board.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Governmental Affairs Council of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee.
(Amended, 1981 Interim Meeting)

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.
(1974 Annual Meeting—Reviewed by Board, 1980)

Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the state society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.
(1978 Interim Meeting)

National Library of Medicine

The Illinois State Medical Society supports the programs of the National Library of Medicine. Fees for subscribers should be based on the current accounting system rather than on total costs.
(1982 Interim Meeting)

Participation in Service Organizations

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.
(Amended, 1980 Interim Meeting)

Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.
(1980 Annual Meeting)

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.
(1976 Interim Meeting, Reviewed by Board, 1982)

Press

In order to provide the public with prompt and accurate information on all health-related matters, all county medical societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The state society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications.

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for this liability coverage.
(Amended, 1978 Interim Meeting)

Public Statements

Only officially designated persons may publicly speak for the society. The chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the society's policies and positions.
(1978 Annual Meeting)

Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.
(1980 Annual Meeting)

Reference Service

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.
(Amended, 1980 Interim Meeting)

Resident Physician Membership

Each regular member of ISMS is encouraged to recruit at least one resident physician member every year, with the regular member providing assistance to the resident in completing the application process for membership.

The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level.
(Amended, 1983 Annual Meeting)

Resident-Student Alternate Delegates to AMA

The Resident Physicians Section and the Medical Student Section shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.
(1979 Annual Meeting)

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.
(1976 Interim Meeting)

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Specialty societies represented on the Council on Affiliate Societies shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.
(1979 Annual Meeting)

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.
(1974 Annual Meeting—Reviewed by Board, 1980)

Policy Manual Appendix

Statement of Understanding

(between patient and physician)

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

ISMS ORGANIZATION

Trustee District Committees

First District

David B. Littman, Highland Park, Trustee
Counties of Kane, Lake, McHenry

Ethical Relations Committee	Term Expires
David Clark, Aurora, *Chairman*	1987
Emanuel Herzon, Elgin	1987
Gerald Liesen, St. Charles	1985
A. M. Rosetti, McHenry	1986

Peer Review Committee	
David Helberg, Waukegan, *Chairman*	1987
Eugene Pitts, Waukegan	1987
James Pritchard, Geneva	1987
Peter Vinceguerra, Libertyville	1987

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford

Ethical Relations Committee	Term Expires
William Erkonen, Streator, *Chairman*	1986
Karl T. Deterding, Pontiac	1986
Julius Kowalski, Princeton	1986
Lawrence D. Lee, Manhattan	1985
Merle Otto, Frankfort	1985
James Ryan, Kankakee	1985

Peer Review Committee	
Louis Tarsinos, Princeton, *Chairman*	1985
James B. Aplington, LaSalle	1985
Robert Betasso, Ottawa	1985
Silvio Davito, Spring Valley	1985
Bernard J. Doyle, LaSalle	1985
William Ehling, Streator	1986
Ross Hutchison, Gibson City	1987
Guy Pandola, Joliet	1987
A.G. Parkhurst, Kankakee	1986
Alex Spadoni, Joliet	1985
Theodore W. Wagenknecht, Streator	1985

Third District

James H. Andersen, M.D., Oak Brook, *Trustee*
Richard Blankshain, Oak Park, *Trustee*
Alfred J. Clementi, Arlington Heights, *Trustee*
Audley F. Connor, Jr., Chicago, *Trustee*
Joan E. Cummings, Hines, *Trustee*
Harold L. Jensen, Flossmoor, *Trustee*
Arthur R. Peterson, Chicago, *Trustee*
Pedro A. Poma, Melrose Park, *Trustee*
Harry A. Springer, Evanston, *Trustee*
Cyril C. Wiggishoff, Chicago, *Trustee*

Fourth District

George Burke, Rock Island, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren

Ethical Relations Committee	Term Expires
Jerry Ramunis, Victoria, *Chairman*	1985
Earl Clark, Rock Island	1987

Peer Review Committee	
James C. Parsons, Geneseo, *Chairman*	1985
Donald Dexter, Macomb	1986
William Dougherty, Moline	1987
Richard Flacco, Galesburg	1985
G. W. Giebelhausen, Peoria	1987
Clarence Ward, Peoria	1987

Fifth District

Robert Prentice, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon

Ethical Relations Committee	Term Expires
Richard H. Suhs, Springfield, *Chairman*	1986
Jack Means, Mason City	1987
A. L. Van Ness, Bloomington	1985

Peer Review Committee

James Borgerson, Mt. Pulaski, *Chairman*	1986
George Irwin, Bloomington	1985
Paul LaFata, Springfield	1986
Robert B. Perry, Lincoln	1985
Donald Yurdin, Springfield	1985
Clifford Draper, Hillsboro	1985
Albert Cunningham, Normal	1986

Sixth District

George T. Wilkins, Edwardsville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Newton DuPuy, Quincy, *Chairman*	1986
Bernard Baalman, Hardin	1987
Edward K. DuVivier, Alton	1986
C. B. Lara, Pittsfield	1987
Robert Roy, Jacksonville	1987

Peer Review Committee

Walter Stevenson III, Quincy, *Chairman*	1986
E. C. Bone, Jacksonville	1985
Robert England, Carlinville	1987
Robert F. Hamilton, Alton	1987
Robert C. Murphy, Quincy	1985
Edward Ragsdale, Alton	1986
James Sutherland, Quincy	1986

Seventh District

Boyd E. McCracken, Greenville, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Delbert H. Hahn, Jr., Decatur, *Chairman*	1985
Muhammad T. Salaymeh, Taylorville	1985
E. F. Stephens, III, Centralia	1985

Peer Review Committee

M. K. Kaufman, Greenville, *Chairman*	1986
H. Gale Zacheis, Decatur	1986
Clarence G. Glenn, Decatur	1985
D. H. Rames, Vandalia	1985

Eighth District

Arthur R. Traugott, Urbana, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1986
Charles L. Lansford, Urbana	1985
James H. Pass, Olney	1987
Stanley R. Huffman, Charleston	1986

Peer Review Committee

George T. Mitchell, Marshall, *Chairman*	1987
Edward S. Warren, Danville	1986
G. Carr, Lawrenceville	1985
R. C. Adams, Champaign	1985

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Alex Goldstein, Harrisburg, *Chairman*	1985
Eli Borkon, Carbondale	1986
Robert Rader, Anna	1986

Peer Review Committee

Philip D. Boren, Carmi, *Chairman*	1985
Larry Jones, Harrisburg	1987
Roger Klam, Carbondale	1987
Harry L. Lewis, Benton	1985
Eugene B. Loftin, Fairfield	1985
Charles K. Wells, Mt. Vernon	1985

Tenth District

Thomas P. Meirink, Belleville, *Trustee*
Counties of Monroe, Perry, Randolph, St. Clair, Washington

Ethical Relations Committee	Term Expires
H. P. Dexheimer, Belleville, *Chairman*	1985
Roy Kenney, E. St. Louis	1985
Edilberto Maglasang, Columbia	1985
Wm. A. Simmons, Belleville	1985

Peer Review Committee

Theodore L. Bryan, Belleville, *Chairman*	1987
Benjamin Arenas, Belleville	1985
R. W. Jost, Waterloo	1987
R. E. Schettler, Red Bud	1986
Ron Welch, Belleville	1987

Eleventh District

Raymond A. Dieter, Jr., Glen Ellyn, *Trustee*
County of DuPage

Twelfth District

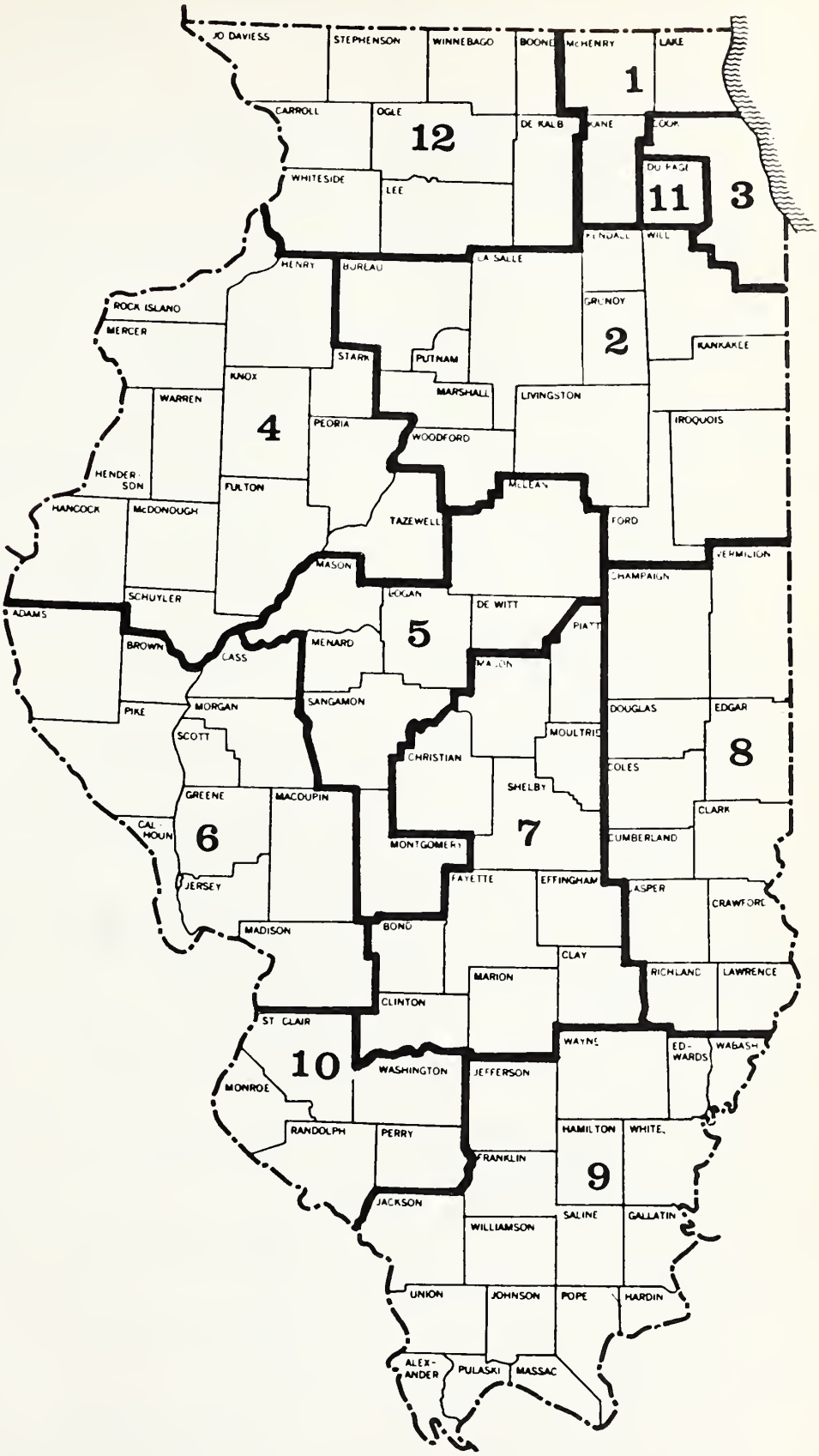
Raymond E. Hoffmann, Rockford, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Ethical Relations Committee	Term Expires
John W. Ovitz, Jr., Sycamore, *Chairman*	1986
William Isham, Freeport	1986
John H. Steinkamp, Belvidere	1987
Daniel Swift, Rockford	1987
Richard S. Webb, Jr., Rockford	1986

Peer Review Committee

John W. Ovitz, Jr., Sycamore, *Chairman*	1986
William Isham, Freeport	1986
John H. Steinkamp, Belvidere	1987
Daniel Swift, Rockford	1987
Richard S. Webb, Jr., Rockford	1986

ISMS TRUSTEE DISTRICTS



1984 Officers of County Medical Societies

County	Members	President	Secretary
Adams	Members: 95-Dist. 6 Maxine Boyer, Ex. Sec. 2039 Sunnybrook P.O. Box 767 Quincy 62306	Ned L. Snider 1115 Maine, Quincy 62301	Richard L. Newman 1225 Broadway, Quincy 62301
Alexander	Members: 7-Dist. 9	Crisostomo Lozada 529 Cross, Cairo 62914	Gemo Wong 529 Cross, Cairo 62914
Bond	Members: 8-Dist. 7	Thomas D. Dawdy Health Care Drive, Greenville 62246	Boyd A. McCracken Health Care Drive, Greenville 62246
Boone	Members: 26-Dist. 12	Alice B. Mijanovich 556 E. Grant, Marengo 60152	John Steinkamp 824 Van Buren, Belvidere 61008
Bureau	Members: 39-Dist. 2	Paul V. Paul 1302 N. Greenwood, Spring Valley 61362	Rakesh K. Garg 600 E. First, Spring Valley 61362
Carroll	Members: 8-Dist. 12	Cecil G. Piper 203 W. Market, Mt. Carroll 61053	Basilios G. Lambos 202 Main St. Savanna 61074
Champaign	Members: 254-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	David W. Morse Carle Clinic, 602 W. University, Urbana 61801	Paul W. Yardy Carle Clinic, 602 W. University, Urbana 61801
Christian	Members: 22-Dist. 7	Muhammad T. Salaymeh 600 N. Main, Taylorville 62568	I. Del Valle 311 S. Main, Taylorville 62568
Clark	Members: 6-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Steven Macke Cork Medical Center, Marshall 62441
Clay	Members: 7-Dist. 7	Alva P. Naney, Jr. 433 E. 7th St., Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
Clinton	Members: 15-Dist. 7	Howard Watson P.O. Box 99, Jamestown Rd. Breese 62230	Jonathan Osborn P.O. Box 99, Jamestown Rd., Breese 62230
Coles-Cumberland	Members: 65-Dist. 8	Gaylin D. Lack P.O. Box 218, Charleston 61920	Donald E. Binz, III 1810 Charleston, Mattoon 61938
Cook	Members: 9558-Dist. 3 Fred Schwartz, Exec. Dir. 515 N. Dearborn St. Chicago, IL 60610	Jere E. Freidheim 3050 S. Wallace, Chicago 60616	Robert M. Vanecko 6200 N. Kilpatrick, Chicago 60946
Crawford	Members: 14-Dist. 8	Michael W. Elliott 1002 N. Allen, Robinson 62454	W.B. Schmidt 408 S. Cross St., Robinson 62454
DeKalb	Members: 60-Dist. 12	William K. Lee 232 S. Second, DeKalb 60115	John D. Wassner 954 W. State, Sycamore 60178
DeWitt	Members: 8-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas	Members: 9-Dist. 8	Humberto Mondul 111 W. South Central, Tuscola 61953	Grant A. Jones 318 S. Ash, Arthur 61911

DuPage	Members: 734-Dist. 11 Lillian Widmer, Ex. Admin. 800 Roosevelt Road Building B-Suite 300 Glen Ellyn 60137	Garth D. Smith 550 N. Monroe, Hinsdale 60521	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar	Members: 15-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham	Members: 24-Dist. 7	Herbert F. Webb P.O. Box 1268, Effingham 62401	Ruben Boyajian P.O. Box 1139, Effingham 62401
Fayette	Members: 11-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth, Vandalia 62471
Ford	Members: 16-Dist. 2	Robert Arthur P.O. Box 527, Gibson City 60926	David J. Hagan 214 N. Sangamon, Gibson City 60926
Franklin	Members: 22-Dist. 9	Yihnan Chiou 406 W. St. Louis St., W. Frankfort 62896	Bob G. Thompson 309 W. St. Louis St., W. Frankfort 62896
Fulton	Members: 38-Dist. 4	John Day 175 S. Main, Canton 61520	Hassan Alsheik P.O. Box 498, 115 N. Main, Canton 61520
Gallatin	Members: 1-Dist. 9	John E. Doyle Ridgway 62979	John E. Doyle Ridgway 62979
Greene	Members: 6-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
Hancock	Members: 9-Dist. 4	Vasant Pawar 216 Parkway Drive, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
Henderson	Members: 1-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	Silvino Lindo, Jr. Biggsville 61418
Henry-Stark	Members: 32-Dist. 4	Donald Ford 648 N. Chicago Geneseo 61254	Richard M. Terry 420 S. Chestnut, Kewanee 61443
Iroquois	Members: 21-Dist. 2	Philip F. Zumwalt P.O. Box 336 Sheldon 60966	A.T. DeVas Gunawardhane Central Comm. Hosp., 5th Ave., Clifton 60972
Jackson	Members: 113-Dist. 9	Lloyd N. McCain 2601 W. Main Carbondale 62901	Clifford L. Coleman 306 W. Main, Carbondale 62901
Jasper	Members: 2-Dist. 8	Juan Jose Serra 507 W. Washington, Newton 62448	Monico Low P.O. Box 377, Newton 62448
Jefferson-Hamilton	Members: 47-Dist. 9	Manoj H. Desai #1 Doctors Park Rd., Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
Jersey-Calhoun	Members: 12-Dist. 6	Robert G. Mindrup 308 S. Washington, Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
Jo Daviess	Members: 9-Dist. 12	David Hockman 219 Summit St., Galena 61036	Francis B. Waites 219 Summit St., Galena 61036
Kane	Members: 324-Dist. 1 H. Michael Wild, Ex. Dir. 355 First St. Batavia 60510	Nasir J. Ahmad 296 W. Spring St., South Elgin 60177	Thomas R. Huberty 1240 N. Highland, Suite 22, Aurora 60506

Kankakee	Members: 106-Dist. 2 Joan Moody, Exec. Sec'y. St. Mary's Hosp., 500 W. Court, Kankakee 60901	Randall L. Mann 401 N. Wall, Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
Kendall	Members: 5-Dist. 2	John P. Cullinan Main & VanBuren, Oswego 60543	Joseph L. Daw Main & VanBuren, Oswego 60543
Knox	Members: 84-Dist. 4 Mrs. Jane Gau, Exec. Sec. 695 N. Kellogg Galesburg 61401	Irene S. Caruso 632 Bondi Bldg., Galesburg 61401	Michael S. Sidell 695 N. Kellogg, Galesburg 61401
Lake	Members: 456-Dist. 1 Jane R. Stein, Exec. Dir. 1117 S. Milwaukee Forum One—Suite 13 Libertyville 60048	Edwin C. Salter 800 N. Westmoreland Rd. Lake Forest 60045	Adam H. Romeiser, Jr. 800 N. Westmoreland Rd. Lake Forest 60045
LaSalle	Members: 112-Dist. 2	Caner Celeboglu 104 6th St., Streator 61364	Allan L. Goslin 712 N. Bloomington, Streator 61364
Lawrence	Members: 10-Dist. 8	Alexander Po RR 4, Lawrenceville 62439	Francisco E. Martin 542 N. Main, Bridgeport 62417
Lee	Members: 27-Dist. 12	Osma Al Masri 403 E. First, Dixon 61021	Tiam H. Lie Rt. 5 Castellan, Dixon 61021
Livingston	Members: 30-Dist. 2	Homer C. Parkhill 202 N. Main, Pontiac 61764	Karl T. Deterding 612 E. Water, #109, Pontiac 61764
Logan	Members: 27-Dist. 5	Steven D. Kottemann 311 8th St., Lincoln 62656	James B. Borgerson 119 S. Vine, Mt. Pulaski 62548
Macon	Members: 166-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	H. Gale Zacheis 301 Hay St., Decatur 62526	Robert D. Miller 1210 S. Jasper, Decatur 62521
Macoupin	Members: 19-Dist. 6	Padmavathi Talcherkar 75 Michael Steven Plaza, Carlinville 62626	Robert England 935 Morgan, Carlinville 62626
Madison	Members: 226-Dist. 6	Sadiq Mohyuddin 1308 W. Delmar, Godfrey 62035	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion	Members: 46-Dist. 7	Secundino E. Rubio Box 109, Salem 62881	W. P. Plassman 630 Short St., Centralia 62801
Marshall-Putnam	Members: 3-Dist. 2	E.R. Resurreccion, Jr. 200 W. St. Paul, Spring Valley 61362	Joe W. Cannon 202 South Main, Lacon 61540
Mason	Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
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McHenry	Members: 89-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Honeid M. Baxamusa 295 Grove St., Crystal Lake 60014	Basudeb Saha 4318 W. Crystal Lake Road, McHenry 60050

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Peoria	Members: 445-Dist. 4 M. John Hanni, Jr., Ex. V.P. 427 1st Nat'l Bank Bldg. Peoria 61602	Chester Danehower, Jr. 5401 N. Knoxville, Peoria 61614	Thomas G. Cassidy 515 N.E. Glen Oak, Peoria 61603
Perry	Members: 13-Dist. 10	Raghuveer M. Kudva, P.O. Box 425, DuQuoin 62832	John G. Fozard 206 N. Main, Pinckneyville 62274
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Pike	Members: 9-Dist. 6	Shehnaz Ansari 623 W. Washington, Pittsfield 62363	Carlos B. Lara 203 N. Madison, PO Box 328, Pittsfield 62363
Randolph	Members: 22-Dist. 10	Allan L. Liefer 415 W. S. Fourth, Red Bud 62278	J. M. Whittenberg 1650 State St., Chester 62233
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St. Clair	Members: 281-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main, Suite 3L Belleville 62223	Robert C. Wanless 6401 W. Main, Belleville 62223	Robert E. Schultz, Sr. 6401 W. Main, Belleville 62223
Saline-Pope-Hardin	Members: 23-Dist. 9	Samir Abdo 1201 Pine St. Eldorado 62930	Han M. Hanafy 203 N. Vine, Harrisburg 62946
Sangamon	Members: 458-Dist. 5 L. R. Brosi, Ex. Adm. 522 E. Monroe, Room 203 Springfield 62701	Michael C. Snyder 326 N. 7th, Springfield 62701	Elvin G. Zook SIU School of Medicine, P.O. Box 3926, Springfield 62708
Schuyler	Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681

Shelby	Members: 10-Dist. 7	P. D. Gurujal Shelby Cty. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
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Tazewell	Members: 69-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	John E. Lovell, 309 Hannible, Tremont 61568	M.A. Sheikh 2900 W. Kingston Ct., Peoria 61604
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White	Members: 7-Dist. 9	Morris A. McCall R.R. 2, Box 132 B, Carmi 62821	Morris A. McCall R.R. 2, Box 132 B, Carmi 62821
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Winnebago	Members: 414-Dist. 12 Robert Carlson, Exec. Adm. 630 E. Jefferson Rockford 61107	Norm A. Hagman P.O. Box 6144, Rockford 61125	Jovenel Dubois 5670 E. State St., Rockford 61108
Woodford	Members: 6-Dist. 2	Victor V. Jay 601 N. Jefferson, Washburn 61570	Victor V. Jay 601 N. Jefferson, Washburn 61570

No Organized County Society: Cass-Brown, Edwards, Johnson, Menard

Joint County Societies: Coles-Cumberland; Henry-Stark; Jefferson-Hamilton; Jersey-Calhoun; Marshall-Putnam; Morgan-Scott; Saline-Pope-Hardin; Will-Grundy.

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Second Vice-President—Ronald G. Welch, 333 S. Illinois, Belleville 62220
Secretary-Treasurer—Alfred J. Kiessel, 1 Powers Lane Place, Decatur 62522
Speaker—Julian W. Buser, 904 S. 59th St. (Copper Bend South) Belleville 62223
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9th District—Warren D. Tuttle, 203 N. Vine, Harrisburg 62946 1987
10th District—Thomas P. Meirink, 8601 W. Main St., Belleville 62223 1987
11th District—Raymond A. Dieter, Jr., 454 Pennsylvania, Glen Ellyn 60137 1986
12th District—Raymond E. Hoffmann, 1030 Highview Ave., Rockford 61107 1986
Trustee-At-Large—Robert P. Johnson, 3000 Bennington Ave., Springfield 62704 1985

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ISMIE Board of Governors Chairman, *Ex Officio*—Fred Z. White, P.O. Box 279, 525 Sweetbriar, Chillicothe 61523

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Herschel Browns* 1981
Edward W. Cannady* 1970
Newton DuPuy* 1968
David S. Fox* 1979
H. Close Hesseltine* 1961
J. M. Ingalls 1976
Charles J. Jannings, III 1972
Frank J. Jirka, Jr.* 1973
Robert P. Johnson 1984
Fredric D. Lake* 1975
Burtis E. Montgomery* 1966
Caesar Portes* 1967
Jacob E. Reisch (Honorary)* 1979
Willard C. Scrivner* 1974
P. John Seward* 1980
Joseph H. Skom* 1977
Leo P. A. Sweeney* 1953
Philip G. Thomsen* 1969
Fred Z. White* 1982
Cyril C. Wiggishoff* 1983
George T. Wilkins 1978
**Also a past trustee or councilor*

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Edward W. Cannady, Belleville 1965-1968
Maurice M. Hoeltgen, Chicago 1968-1970
Paul W. Sunderland, Gibson City 1970-1973
Andrew J. Brislen, Chicago 1973-1975
James A. McDonald, Geneva 1975-1977
Cyril C. Wiggishoff, Chicago 1977-1979
Robert P. Johnson, Springfield 1979-1981
Clifton L. Reeder, Wilmette 1981-1983

Ex-Officio Members of the House without the Right to Vote

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Raymond DesRosiers, Chicago, Trustee of the 3rd District
Herbert Dexheimer, Belleville, Trustee of the 10th District
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Robert T. Fox, Chicago, Trustee of the 3rd District
Jere Freidheim, Chicago, Trustee of the 3rd District
Morris T. Friedell, Chicago, Trustee of the 3rd District
Lee N. Hamm, Lincoln, Trustee of the 5th District
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Lawrence L. Hirsch, Northbrook, Trustee of the 3rd District
Eugene Hoban, Chicago, Trustee of the 3rd District
Kenneth Hurst, Naperville, Trustee of the 11th District
Ross Hutchison, Gibson City, Trustee of the 11th District
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Joseph C. Sherrick, Chicago, Trustee of the 3rd District
George Shropshear, Chicago, Trustee of the 3rd District
Darrell H. Trumpe, Springfield, Trustee of the 5th District
Frederick E. Weiss, Harvey, Trustee of the 3rd District
Charles K. Wells, Mt. Vernon, Trustee of the 9th District
Herman Wing, Chicago, Trustee of the 3rd District
Warren W. Young, Chicago, Trustee of the 3rd District

ISMS DELEGATION TO THE AMA

Delegation Chairman: Howard C. Burkhead; Secretary: Morgan M. Meyer

Delegates

To serve from Jan. 1, 1983 to Dec. 31, 1984
(Elected April 17, 1982)

David S. Fox, Chicago
Morris T. Friedell, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Northbrook
Michael Nieder, Chicago*
Joseph R. O'Donnell, Glen Ellyn
John J. Ring, Mundelein
P. John Seward, Rockford
George T. Wilkins, Granite City
Fred Z. White, Chillicothe**

To serve from Jan. 1, 1984 to Dec. 31, 1985
(Elected April 24, 1983)

Howard C. Burkhead, Evanston
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Morgan M. Meyer, Lombard
Joseph H. Skom, Chicago
Arthur Traugott, Urbana
Cyril C. Wiggishoff, Chicago

To serve from Jan. 1, 1985 to Dec. 31, 1986
(Elected April 8, 1984)

Audley F. Connor, Jr., Chicago
David S. Fox, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Northbrook
Michael Nieder, Chicago
Joseph R. O'Donnell, Glen Ellyn
P. John Seward, Rockford
Fred Z. White, Chillicothe
George T. Wilkins, Granite City

Alternates

To serve from Jan. 1, 1983 to Dec. 31, 1984
(Elected April 17, 1982)

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
James DeBord, Peoria***
Robert P. Johnson, Springfield
Alfred J. Kiessel, Decatur
Carlos B. Lara, Pittsfield**
Joseph Perez, Peoria
Clifton L. Reeder, Wilmette
Harry Springer, Chicago
Richard Terek, Chicago*

To serve from Jan. 1, 1984 to Dec. 31, 1985
(Elected April 24, 1983)

Randall T. Bellows, Chicago
Jere Freidheim, Chicago
Allan Goslin, Streator
Harold Jensen, Flossmoor
A. Beaumont Johnson, Elgin
Pedro A. Poma, Melrose Park
Warren D. Tuttle, Harrisburg
Ronald Welch, Belleville
Fred Z. White, Chillicothe

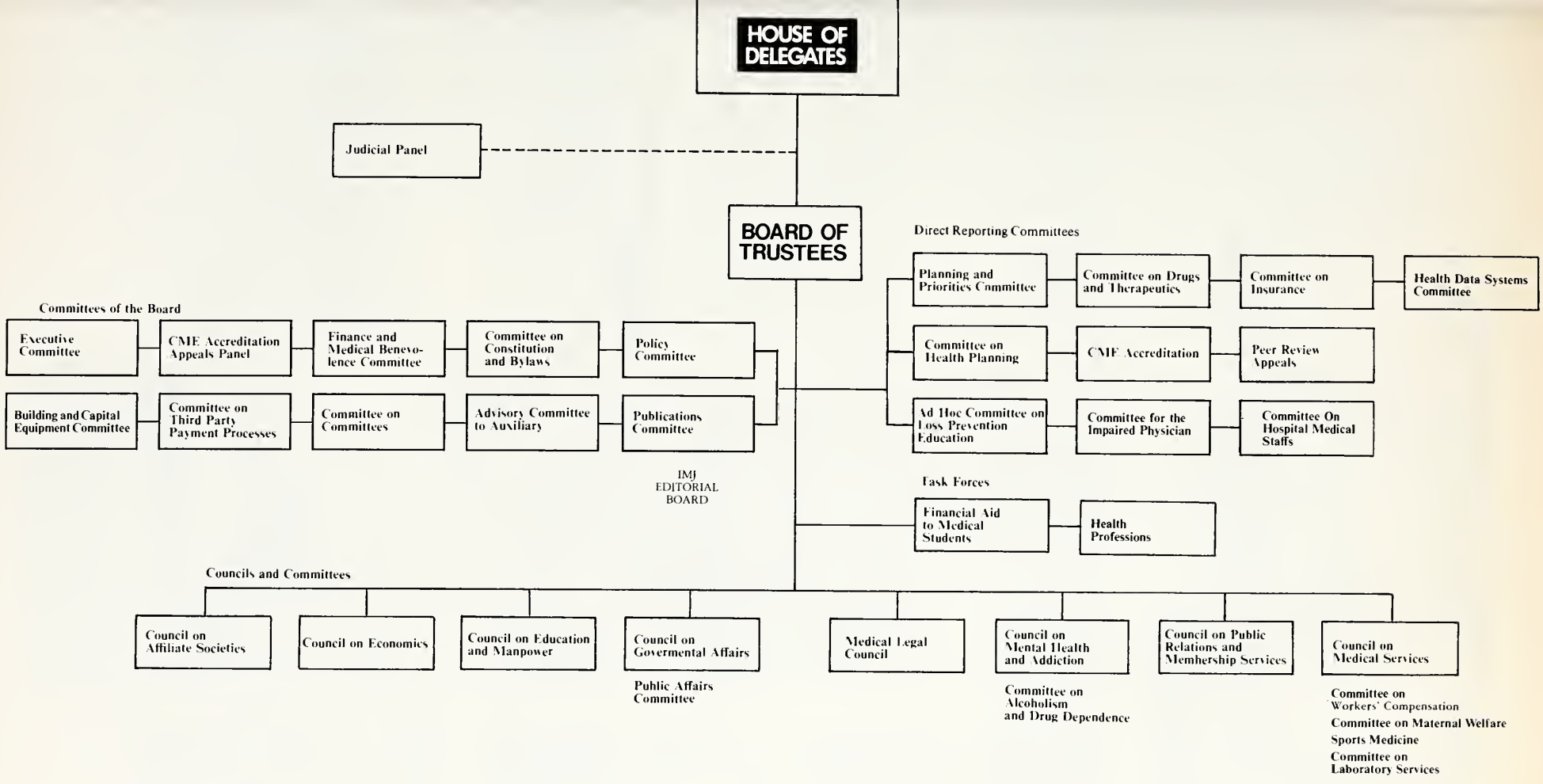
To serve from Jan. 1, 1985 to Dec. 31, 1986
(Elected April 8, 1984)

James H. Andersen, Oak Brook
James DeBord, Peoria
Alfred J. Kiessel, Decatur
Carlos B. Lara, Pittsfield
Joseph B. Perez, Rockford
Clifton L. Reeder, Wilmette
Harry Springer, Chicago
Robert M. Vanecko, Chicago
Nancy Zamora, Rockford

**Elected April 24, 1983 to seventeenth position*
***Elected April 8, 1984 to complete unexpired term through Dec. 31, 1984*
****Elected April 24, 1983 to complete unexpired term beginning Jan. 1, 1984*

Honorary Members

Frank J. Jirka, Jr., Barrington Hills; Burtis E. Montgomery, New York; John J. Ring, Mundelein



Organizations Directly Related to ISMS

- Illinois Foundation for Medical Care
- Illinois Council on Continuing Medical Education
- Illinois State Medical Benevolent Fund, Inc.
- Illinois State Medical Insurance Services, Inc.
- Illinois State Medical Inter-Insurance Exchange
- ISMS Educational and Scientific Foundation
- Medical Student Section
- Resident Physician Section

Organizations with formal ISMS Representation

- Swanberg Foundation
- Ill. Society, American Association of Medical Assistants
- Ill. Interagency Council on Smoking and Disease
- M.D. Committee on Optometry
- The Commission on Children
- INA/ISMS Joint Practice Comm.
- Ill. Medical Records Assn.
- Illinois Cancer Council
- IMPAC
- Citizen's Committee on an Illinois Program to Control High Blood Pressure
- U. S. Pharmacopaeia
- Ill. Migrant Council
- Student Loan Fund Board, ISMS/IAA

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, Speaker of the House, and Chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

COUNCIL ON AFFILIATE SOCIETIES

William Barnhart, Chicago, Illinois Society of Internal Medicine
Robert Borkenhagen, Indian Head Park, Chicago Laryngological & Otological Society
James H. Cravens, Quincy, Illinois Chapter, American Academy of Pediatrics
William Gottschalk, Winnetka, Illinois Society of Anesthesiologists, Inc.
Theodore M. Kanellakes, Joliet, Allergy & Clinical Immunology Society of Illinois
James Kurtz, Hines, Illinois Orthopaedic Society
Guy R. Matthew, Chicago, Illinois Radiological Society
John E. Meyenberg, Chicago, Illinois Chapter, American Academy of Family Physicians
Robert C. Muehrcke, Oak Park, Illinois Chapter, American College of Physicians
David H. Paul, Belleville, Illinois Chapter, American College of Emergency Physicians
Milton Robin, Chicago, Illinois Dermatological Society
Stanley S. Smith, Jr., Urbana, Illinois OB-GYN Society
William B. Spriegel, Evanston, Illinois Psychiatric Society
Jay Subbarao, Wheaton, Illinois Society of Physical Medicine & Rehabilitation
Jeffrey Tennant, Oak Lawn, Illinois Association of Ophthalmology
George D. Wilbanks, Chicago, Illinois Section, American College of OB-Gyn

Other Organizations Represented
Illinois Chapter, American College of Surgeons
Illinois Neurological Society
Illinois Society of Ophthalmology & Otolaryngology
Illinois Society of Pathologists
Illinois State Urological Society
Illinois Surgical Society
Illinois Thoracic Surgical Society

Consultants:
Richard H. Blankshain, Oak Park
George H. Burke, Rock Island
Raymond A. Dieter, Jr., Glen Ellyn
Raymond E. Hoffmann, Rockford

Responsibilities and Purposes:

To improve communications and provide liaison with the specialty societies; provide specialty consultations to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

COUNCIL ON ECONOMICS

Fred Z. White, Chillicothe, *Chairman*
William D. Barnhart, Chicago
Juanito S. Bartolome, Chicago
Lorris M. Bowers, Peoria
Irene S. Caruso, Galesburg
Patrick E. Ebenhoeh, Chicago
Bernard J. Feldman, Chicago
A. Beaumont Johnson, Elgin
Donald K. J. Rokosch, Danville
Gerald E. Silverstein, Chicago
Robert C. Wanless, Belleville

Student
Thomas Zusag, Chicago

Resident
James W. Scruggs, East Peoria

Consultants:
Harold L. Jensen, Flossmoor
Arthur R. Traugott, Urbana
Ronald G. Welch, Belleville

Responsibilities and Purposes:

The Council on Economics considers issues that are of direct and immediate economic concern to the practice of medicine in Illinois. The council is interested in effective practice management and the economic impact of governmental health care activities and policies, private health care initiatives, alternative health care delivery systems and the activities of the various utilization review agencies (i.e., PRO, Foundations for Medical Care and private preadmission review initiatives). The council analyzes the impact of these programs, both existing and proposed, and reports its recommendations to the Board of Trustees.

COUNCIL ON EDUCATION AND MANPOWER

Eugene B. Loftin, Fairfield, Chairman
Francois Alouf, Chicago
Patrick Anderson, Chicago
Earl Fredrick, Olympia Fields
Mary Jensen, Chicago
Ronald Johnson, Pittsfield
Santosh Lal, Chicago
Natalie Stephens, Chicago
Bernard Wetchler, Peoria

Resident Representative
John Diveris, Glenview

Student Representative
Alan J. Scharrer, Springfield

IMGMA Representative
Steven R. Perrigo, Springfield

Consultants
Lawrence L. Hirsch, Northbrook
Robert P. Johnson, Springfield
Boyd McCracken, Sr., Greenville

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for allied health personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

GOVERNMENTAL AFFAIRS COUNCIL

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Edward Ference, Springfield
David S. Fox, Chicago
George T. Mitchell, Marshall
Tassos Nassos, Northbrook
John Ovitz, Sycamore
Joseph Purpura, Lake Forest
Edward Ragsdale, Alton
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Earl Suckow, Mt. Prospect
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Patrick Stodolo, Chicago

Consultants
Howard Burkhead, Evanston
Ronald Welch, Belleville
Cyril C. Wiggishoff, Chicago
George T. Wilkins, Edwardsville

Illinois Medical Group Management Association Representative
Dennis Mock

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs

PUBLIC AFFAIRS COMMITTEE

Herbert Sohn, Chicago, *Chairman*
Louis Dondanville, Moline
Edwin Falloon, Palos Heights
Delbert H. Hahn, Decatur
Don E. Hinderliter, Rochelle
Frank J. Jirka, Jr., Barrington Hills
Harold Lasky, Chicago
Paul F. Mahon, Springfield
Albert W. Ray, Jr., Joliet
Richard Schenk, Urbana
Patrick Staunton, Park Ridge
A. E. Steer, Springfield

IMGMA Representative
Robert Thompson, Champaign

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

MEDICAL LEGAL COUNCIL

Donal D. O'Sullivan, Oak Park, *Chairman*
Geoffrey Bland, Springfield
James L. Cavanaugh, Winnetka
Robert Eilers, Burr Ridge
Gerardo Grieco, Chicago
Kenneth D. Hansen, Carbondale
Saul Haskell, Chicago
David B. Lewis, Springfield
Robert Libman, Chicago
Michael G. Victor, Barrington
Harold Walgren, Downers Grove
Julius J. Wineberg, Waukegan

Resident Representative
Lois Margaret Nora

Student Representative
Ronald Shouten

Consultants
Donald Aaronson, Chicago
James Andersen, Oak Brook
Howard C. Burkhead, Evanston
Raymond Dieter, Jr., Glen Ellyn
Morgan Meyer, Lombard
Warren D. Tuttle, Harrisburg

Responsibilities and Purposes:

The Council shall cooperate with all organizations interested in medico-legal problems and educate members of the profession in such affairs. In addition, the Council shall be concerned with standards of practice, licensure and quackery.

This Council shall maintain liaison with the Illinois State Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel and the Worker's Compensation Roster. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

COUNCIL ON MEDICAL SERVICES

Joseph D. Winterhalter, Jacksonville, *Chairman*

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Henry Dold, Arlington Heights
C. Larkin Flanagan, Chicago
Henrietta Herbolsheimer, Chicago
Janice Herz, Melrose Park
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Leslie E. Mathers III, Peoria
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Forrest H. Riordan, III, Rockford
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Nunilo Rubio, Chicago
Alan Stein, Alton

Consultants:
Raymond E. Hoffmann, Rockford
David Littman, Highland Park

Auxiliary Representative
Mrs. Selig Hodes, Forreston

Student Representative
David Margolis, Chicago

Resident Representative
Michael Reirmaier, Chicago

Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, laboratory services and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workers' compensation, and the penal health care services.

Committees:

Laboratory Services
Maternal Welfare
Sports Medicine
Workers' Compensation

COMMITTEE ON LABORATORY SERVICES

John Mason, Oak Lawn, Chairman
Rudsen M. Bueser, Hinsdale
Thomas Harwood, Chicago
C. M. Modi, Chicago
Vincent T. Mosquera, Clarendon Hills
Richard J. Sassetti, Chicago
Antoinette Thomas, Carbondale

Consultant:
Alfred J. Kiessel, Decatur

Responsibilities and Purposes:

The Committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

COMMITTEE ON MATERNAL WELFARE

District Members and Alternates
(alternates in italics)

1. Joseph Burke, Waukegan
William R. Larsen, Woodstock
2. Carl P. Mattioda, Streator
Leo Wrona, M.D., Joliet
3. Marvin A. Rosner, Chicago, *Chairman*
Warren H. Staley, Chicago
4. Raoul E. Reinertsen, Canton
Robert Westerfer, Peoria
5. William H. Schultz, Springfield
Kofi S. Amankwah, Springfield
6. Richmond H. Simmons, Jacksonville
Richard D. Yoder, Alton
7. Herbert W. Thompson, Decatur
8. Lewis Trupin, Champaign
Larry R. Lane, Champaign
9. Cynthia A. Fraed, Harrisburg
Allan G. Bennett, Carbondale
10. Stephen V. Mueller, Belleville
Casimiro Garcia, Jr., Belleville
11. A. William Schafer, Hinsdale
Thomas R. Eckman, Downers Grove
12. John E. Tillis, Rockford
John T. Leonard, Rockford

Consultants:
William Gottschalk, Winnetka
Robert R. Hartman, Jacksonville
John Louis, Lake Forest
Augusta Webster, Chicago

Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

SPORTS MEDICINE COMMITTEE

Henry J. Dold, Arlington Heights *Chairman*
David Anzaldua, Peoria
Craig Dean, Libertyville
Clarence Fossier, Lake Forest
James L. Green, Jacksonville
Ed Grogg, Urbana
James A. Hill, Chicago
William T. Sheehy, Elgin
Howard J. Sweeney, Evanston
Eugene Tanski, Chicago

Consultants:
Audley F. Connor, Jr., Chicago
J. M. Ingalls, Paris

Auxiliary Representative
Mrs. Harold Keegan, Kankakee

Responsibilities and Purposes:

The committee conducts programs aimed at improving the recognition and treatment of athletic-related injury and disease; provides educational material to junior and senior high school coaches and trainers; and works with other groups and organizations involved in sports medicine activities.

COMMITTEE ON WORKERS' COMPENSATION

Forrest H. Riordan, III, Rockford, *Chairman*
Ernest Adams, Peoria
E. Richard Blonsky, Chicago
Milton R. Carlson, Champaign
Richard Geline, Skokie
Alvin Palow, Kankakee
James R. Ryan, DesPlaines
Michael R. Treister, Chicago

Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the workers' compensation system in Illinois.

COUNCIL ON MENTAL HEALTH AND ADDICTION

LeRoy P. Levitt, Chicago, *Chairman*
Fern E. Asma, Chicago
Richard Banta, Rockford
S. Dale Loomis, Chicago
Silvana Menendez, Belleville
Thomas Minogue, Urbana
Garth Smith, Hinsdale
Kishore Thampy, Chicago

Consultants:
Joan Cummings, Hines
Allan L. Goslin, Streator
Arthur R. Traugott, Urbana

Auxiliary Representative
Mrs. Alex Spadoni, Hinsdale

Student Representative
David O'Brien, Oak Park

Resident Representative
Frank Pieri, Chicago

Responsibilities and Purposes:

This council serves as a source of information on mental health matters for ISMS, evaluates information and makes recommendations to the Board of Trustees on positions the Society should take on issues in this area and cooperates with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse. It is also concerned with reviewing legislation and regulations related to the fields of mental health, alcoholism, drug abuse and controlled substances.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Richard Banta, Rockford, *Chairman*
H. Constance Bonbrest, Chicago
Ulrich Danckers, Melrose Park
Andrew Griffin, Maywood
Peter Talso, Chicago
Ruth Wharton, River Forest

Consultants:
Roalda J. Alderman, Dept. of Alcoholism and Substance Abuse
Donald W. Behnke, Dept. of Alcoholism and Substance Abuse

Auxiliary Representative
Lynn Kassel, Joliet

IMGMA Representative
Barbara Birnbaum, Chicago

Responsibilities and Purposes:

The committee works closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Albino T. Bismonte, Gurnee, *Chairman*
James Bauer, Peoria
Boone Brackett, Oak Park
Jane Jackman, Springfield
Ronald L. Kirschner, Glenview
Frank Padour, Chicago
Reuben Ramkissoon, Hinsdale
Marie-Claude Rigaud, Aurora
David A. Rothstein, Chicago

Consultants:
Robert C. Hamilton, Chicago
Morgan Meyer, Lombard
Pedro A. Poma, Melrose Park
Ronald G. Welch, Belleville

Consultants, County Executives:
John Hanni, Peoria
Fred Schwartz, Chicago
Lillian Widmer, Glen Ellyn
Madge Williams, Bloomington

Resident Representative
Mark Ridlen, Springfield

Student Representative
Michael Kochman, Chicago

Auxiliary Representative
Mrs. Paul Stanley, Decatur

IMGMA Representative
John Robertson

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socioeconomic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

Committees of the Board of Trustees

ADVISORY COMMITTEE TO ISMS AUXILIARY

Robert P. Johnson, Springfield, *Chairman*
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago

Responsibilities and Purposes:

The Committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The Committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members. It shall also monitor the services provided by ISMS to the Auxiliary.

BUILDING AND CAPITAL EQUIPMENT COMMITTEE

Alfred J. Kiessel, Decatur, *Chairman*
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago
Morgan M. Meyer, Lombard
Warren D. Tuttle, Harrisburg
Cyril C. Wiggishoff, Chicago

Responsibilities and Purposes:

The Committee shall review and monitor activities pertaining to the building and capital equipment.

COMMITTEE ON COMMITTEES

Harold L. Jensen, Flossmoor, *Chairman*
Jere E. Freidheim, Chicago
Allan L. Goslin, Streator
Raymond E. Hoffmann, Rockford

Responsibilities and Purposes:

The Committee on Committees shall consist of members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The Committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON CONSTITUTION AND BYLAWS

Thomas P. Meirink, Belleville, *Chairman*
Julian W. Buser, Belleville
Lawrence L. Hirsch, Northbrook
Harold L. Jensen, Flossmoor
George T. Wilkins, Edwardsville

Responsibilities and Purposes:

The Committee on Constitution and Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

CME ACCREDITATION APPEALS PANEL

Joan Cummings, Glen Ellyn
Morgan M. Meyer, Lombard
Pedro A. Poma, Melrose Park
Harry A. Springer, Evanston
Warren D. Tuttle, Harrisburg
Fred Z. White, Chillicothe
George T. Wilkins, Edwardsville

Responsibilities and Purposes:

In the event the Committee on CME Accreditation makes a non-accreditation decision to an Illinois CME sponsor, the sponsor may make a formal appeal to this hearing committee, which, in turn, will make a formal recommendation to the ISMS Board of Trustees on the sponsor's application.

EXECUTIVE COMMITTEE

Alfred J. Clementi, Arlington Heights, *Chairman*
Jere E. Freidheim, Chicago
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Alfred J. Kiessel, Decatur
Morgan M. Meyer, Lombard
Warren D. Tuttle, Harrisburg
Cyril C. Wiggishoff, Chicago

Ex Officio (without vote)
Howard C. Burkhead, Evanston
Julian W. Buser, Belleville
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, the chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Cyril C. Wiggishoff, Chicago, *Chairman*
Alfred J. Kiessel, Decatur
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana

Auxiliary Representatives
Mrs. Louis Tarsinos
Mrs. Darlene Stevenson

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the Society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

POLICY COMMITTEE

George Burke, Rock Island, *Chairman*
James H. Andersen, Oak Brook
Richard H. Blankshain, Oak Park

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.

PUBLICATIONS COMMITTEE

Pedro A. Poma, Melrose Park, *Chairman*
Joan E. Cummings, Hines
Raymond A. Dieter, Jr., Glen Ellyn
David B. Littman, Highland Park
Arthur R. Peterson, Chicago

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, shall review all new accounts prior to acceptance and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*
Eli L. Borkon, Carbondale
Joseph R. Christian, Chicago
Ediz Z. Ezdinli, Kenilworth
Larry C. Gunn, Hinsdale
Eugene J. Rogers, Chicago
Constantine S. Soter, Arlington Heights
David E. Trachtenbarg, Peoria
Donald D. VanFossan, Springfield
Edward A. Wolpert, Chicago

THIRD PARTY PAYMENT PROCESSES COMMITTEE

Arthur R. Traugott, Urbana, *Chairman*
James H. Andersen, Oak Brook
Audley F. Connor, Jr., Chicago
Allan L. Goslin, Streator
Alfred J. Kiessel, Decatur
Boyd E. McCracken, Greenville
Arthur R. Peterson, Chicago
Robert L. Prentice, Springfield
Ronald G. Welch, Belleville

ISIM Representatives
Gershom K. Greening, Springfield (Alt.)
Ronald L. Ruecker, Decatur

Ill. Medical Group Mngmt. Assoc. Rep.
Nancy Koch, Chicago

Responsibilities and Purposes:

The Committee on Third Party Payment Processes is a committee of the Board of Trustees. Its primary responsibility is to interact with the appropriate governmental and private third party reimbursement agencies on matters that require a negotiating role at the Board level. It monitors the activities of the Illinois Department of Public Aid, the Medicare program in Illinois, the CHAMPUS program in Illinois, Blue Cross/Blue Shield, other private insurers and other appropriate agencies that have a significant impact on physician reimbursement programs. This committee negotiates with those entities under the direction of the Board of Trustees to effect appropriate changes in their policies, procedures and programs.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON CME ACCREDITATION

Terry F. Hatch, Urbana, *Chairman*
Walter F. Kondratowicz, Chicago
Joseph P. McKay, Elmhurst
Anthony Sapienza, Chicago
Birendra K. Sinha, Elk Grove Village
Dennis J. Stanczyk, Belleville
Simon Zivin, Lincolnwood

Consultant:
Harold L. Jensen, Flossmoor
Fred Z. White, Chillicothe

Responsibilities and Purposes:

Adopt necessary procedural rules and prescribe forms to be used in the conduct of CME accreditation, within prescribed policies. Review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

ILLINOIS CME SPONSORS ACCREDITED FOR CONTINUING MEDICAL EDUCATION AS OF SEPTEMBER 30, 1984

Alexian Brothers Medical Center—Elk Grove Village
American Heart Assn. (Ill. Affiliate)
Augustana Hospital—Chicago
Belleville Hospital Association for CME (Memorial Hospital, St. Elizabeth Hospital)
Carle Foundation Hospital—Urbana
Central Community Hospital—Chicago
Central DuPage Hospital—Winfield
Chicago Center Hospital
Chicago College of Osteopathic Medicine
Chicago Medical Society
Christ Hospital—Oak Lawn
Columbus-Cuneo-Cabrini Medical Center—Chicago
Condell Memorial Hospital—Libertyville
Copley-Mercy CME Consortium—Aurora
DuPage County Medical Society
Edgewater Hospital, Chicago
Elgin Mental Health Center
FAB^3-CME—(Forkosh Memorial, Belmont Community, Bethesda, Bethany Methodist, Thorek Medical Center) Chicago
Forest Hospital—DesPlaines
Franciscan Medical Center—Rock Island
Glendale Heights Community Hospital
Good Samaritan Hospital—Downers Grove
Good Samaritan Hospital—Mt. Vernon
Gottlieb Memorial Hospital—Melrose Park
Grant Hospital of Chicago
Henry Horner Childrens' Center—Chicago
Highland Park Hospital
Hinsdale Sanitarium & Hospital
Holy Cross Hospital—Chicago
Humana Hospital—Hoffman Estates
Hyde Park Community Hospital—Chicago
Illinois Council on Continuing Medical Education
Illinois Masonic Medical Center—Chicago
Ingalls Memorial Hospital—Harvey
Institute for Psychoanalysis—Chicago
Jackson Park Hospital—Chicago
Kishwaukee Community Health Center—DeKalb
Lake Forest Hospital
Loretto Hospital—Chicago
Louis A. Weiss Memorial Hospital—Chicago
Loyola University Stritch School of Medicine—Maywood
Lutheran General Hospital—Park Ridge
Lutheran Hospital—Moline
MacNeal Memorial Hospital—Berwyn
Martha Washington Hospital—Chicago
Mary Thompson Hospital—Chicago
Memorial Hospital of DuPage County—Elmhurst

Mercy Hospital & Medical Center—Chicago
The Methodist Medical Center of Illinois—Peoria
Mount Sinai Hospital Medical Center of Chicago
Northwestern University Medical School—Chicago
North Shore Mental Health Association/Irene Josselyn Clinic—Northfield
Northwest Hospital—Chicago
Northwest Community Hospital—Arlington Heights
Norwegian-American Hospital—Chicago
Oak Forest Hospital
Oak Park Hospital
Prairie Cardiovascular Center—Springfield
Provident Hospital—Chicago
Ravenswood Hospital Medical Center—Chicago
Resurrection Hospital—Chicago
Riveredge Hospital—Forest Park
Riverside Hospital—Kankakee
Rockford Memorial Hospital
Rush Medical College—Chicago
St. Anne's Hospital—Chicago
St. Anthony Hospital—Chicago
St. Anthony Hospital—Rockford
St. Elizabeth's Hospital—Chicago
St. Elizabeth Hospital—Danville
St. Francis Hospital—Blue Island
St. Francis Hospital—Evanston
St. Francis Hospital-Medical Center—Peoria
St. Joseph Hospital—Chicago
St. Joseph Hospital—Elgin
St. Mary's Hospital—Kankakee
St. Mary's Hospital—Streator
St. Mary of Nazareth Hospital—Chicago
St. Therese Hospital—Waukegan
Sarah Bush Lincoln Health Center—Mattoon
Sherman Hospital—Elgin
Shriner's Hospital for Crippled Children—Chicago
Silver Cross Hospital—Joliet
Skokie Valley Community Hospital—Skokie
South Chicago Community Hospital
Southern Illinois University School of Medicine—Springfield
Springfield Clinic
Swedish American Hospital—Rockford
Swedish Covenant Hospital—Chicago
University of Chicago Pritzker School of Medicine
University of Health Sciences/The Chicago Medical School
University of Illinois College of Medicine
Victory Memorial Hospital—Waukegan
Westlake Community Hospital—Melrose Park
West Suburban Hospital—Oak Park
Woodlawn Hospital—Chicago

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
Amin N. Daghestani, Skokie
Dorothy Hubler, Casey
Martin J. Kaplan, Highland Park
Allan Lorincz, Chicago
Arthur Marks, Fairfield
Robert Reeder, St. Charles

Consultants:
Joan Cummings, Hines
Harold L. Jensen, Flossmoor
Arthur R. Peterson, Chicago
A. Samuel Enloe, R.Ph., Decatur
Dawn Atkins-Gottrich, IDPA

Responsibilities and Purposes:

The committee shall meet periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to list new products in the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Comments or suggestions made by the membership regarding drug products also are reviewed by the committee.

HEALTH DATA SYSTEMS COMMITTEE

Audley F. Connor, Jr., Chicago, *Chairman*
Andrew Brislen, Chicago
Alexander Goldstein, Harrisburg
Allan Goslin, Streator
Henrietta Herbolsheimer, Chicago
Joseph R. O'Donnell, Glen Ellyn
Clifton L. Reeder, Wilmette
Walter Stevenson III, Quincy
Ben T. Williams, Urbana

Consultant:
Alexander R. Lerner

Responsibilities and Purposes:

The committee shall maintain ongoing awareness of: (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of governmental agencies and others with respect to the collection and dissemination of health care data. To the extent feasible, the Committee shall provide informal liaison between the foregoing organizations and ISMS. The committee shall keep the officers, Board of Trustees and other appropriate persons within ISMS advised on data collection matters.

COMMITTEE ON HEALTH PLANNING

Robert M. Vanecko, Chicago, *Chairman*
Martin E. Bruetman, Palos Heights
Robert D. Dooley, Oak Brook
Norris R. Dougherty, Rockford
Mark E. Swislow, Chicago

Consultants:
James H. Andersen, Oak Brook
George H. Burke, Rock Island
Alfred J. Kiessel, Decatur
David B. Littman, Highland Park

Auxiliary Representative
Lory Winterhalter, Jacksonville

Other Representatives
Darlene Duff, Humana Inc., Libertyville

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local health systems agencies. The Committee also monitors health care coalitions in Illinois and reports to the Board on coalition activities.

COMMITTEE ON HOSPITAL MEDICAL STAFFS

Raymond A. Dieter, Jr., Glen Ellyn, *Chairman*
Albino T. Bismonte, Gurnee
Joan E. Cummings, Hines
Allan L. Goslin, Streator
Silvana Menendez, Belleville
Thomas C. Malvar, Chicago
Joseph L. Murphy, Chicago
Lawrence A. Stone, Des Plaines
Jaroslav F. Neskodny, Berwyn
Warren D. Tuttle, Harrisburg

Responsibilities and Purposes:

The Committee shall address the concerns and develop programs for ISMS members as physicians on hospital medical staffs in their association with the administration and governing boards of hospitals. The committee shall keep abreast of developments in hospital-medical staff relationships; monitor and work with the AMA Hospital Medical Staff Section and ongoing efforts organized by component societies; and to the extent feasible, provide informal liaison with organizations impacting on Illinois hospital medical staffs.

COMMITTEE FOR THE IMPAIRED PHYSICIAN

L. Michael Newman, Evanston, *Chairman*
Richard Banta, Rockford
Violet Eggert, Tinley Park
Lee Gladstone, Chicago
Richard Lee, Peoria
LeRoy Levitt, Chicago
Michael G. Murphy, Belleville
Richard L. Newman, Quincy
Albert S. Norris, Springfield
Homer Parkhill, Pontiac
Glen D. Pittman, Springfield
Reinhold Schuller, Bourbonais
Donald Sellers, Des Plaines
Craig Showalter, Chicago
W. David Steed, Oak Park
Peter Talso, Chicago
Herbert Trace, Evanston
William J. Weigel, Aurora

Responsibilities and Purposes:

The Committee for the Impaired Physician consists of physicians who counsel fellow physicians for problems related to alcohol or drug dependence, as well as impairment due to physical disabilities, mental or emotional disturbances, in a confidential and professional manner. It provides information and conducts educational programs on dealing with impairment.

COMMITTEE ON INSURANCE

Anne L. Barlow, North Chicago, *Chairman*
Dominic J. Allocco, Frankfort
Herbert Epstein, Glencoe
William A. Henry, Springfield
James G. Hull, Belleville
Warren C. Jenkins, Northbrook

Consultants:
Alfred J. Kiessel, Decatur

Warren D. Tuttle, Harrisburg

IMGMA Representative
Gerald T. O'Brien, Chicago

Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. Current policies and new types of insurance programs are evaluated in order to recommend changes that may benefit society members. The Committee works closely with the program's administrator, Corroon & Black, Inc.

AD HOC COMMITTEE ON LOSS PREVENTION EDUCATION

Donald Aaronson, Chicago, *Chairman*
Randall T. Bellows, Chicago
Phillip Boren, Carmi
Norman Brill, Olympia Fields
Sara C. Charles, Chicago
Robert R. Hartman, Jacksonville
Clifton L. Reeder, Wilmette
Richard Wilbur, Lake Forest

Consultants
Alfred J. Clementi, Arlington Heights

Donal D. O'Sullivan, Oak Park
Warren D. Tuttle, Harrisburg

Responsibilities and Purposes:

The Ad Hoc Committee on Loss Prevention Education seeks to help physicians identify legal dicta and court procedures and the application of these to medical practice. It seeks to enable physician identification of potential problems in various medical procedures and practice settings and effect a change in same. Educational efforts are intended to improve the quality of medical care and prevent law suits.

PEER REVIEW APPEALS COMMITTEE

George J. Gertz, Chicago, *Chairman*
Boone Brackett, Oak Park
Harry L. Lewis, Benton
Helen Morrison, Chicago
James Russell, Downers Grove
Anne Marie Shute, Highland Park

Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relations issues. The committee is the state Society's liaison to local peer review committees and monitors review activities around the state.

PLANNING AND PRIORITIES COMMITTEE

Members of this committee are appointed annually by the ISMS President-Elect.

Responsibilities and Purposes:

The President-Elect shall serve as the chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

Fred Z. White, Chillicothe, *Chairman*
George Beranek, Chicago
Julian W. Buser, Belleville
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Cyril C. Wiggishoff, Chicago

Auxiliary Representative
Diane Hinderliter, Rochelle

Responsibilities and Purposes:

The Task Force on Financial Aid to Medical Students shall be responsible for developing and maintaining a student loan program through the Educational & Scientific Foundation to assist Illinois medical students in meeting financial obligations of an undergraduate medical school program. In particular, this Task Force shall explore ways and means of raising funds for the development of a student loan program and, through the ISMS Educational and Scientific Foundation, establish guidelines and administration for such a program.

TASK FORCE ON HEALTH PROFESSIONS

Allan Goslin, Streator, *Chairman*
Hubert Allen, Chicago
Peter E. Friedell, Chicago
Joseph Perez, Rockford
Pedro A. Poma, Melrose Park

Consultant
Jack Gibbs, Canton

Responsibilities and Purposes:

The Task Force on Health Professions shall be responsible for providing a discussion forum for common issues affecting physicians and representatives of health professions who work under close physician supervision in the day to day care of patients. This Task Force shall monitor credentialing and licensure of such professionals by the State of Illinois. It shall also consider conducting symposia on health professions.

Direct Reporting Committees of the House of Delegates

JUDICIAL PANEL COMMITTEE

	Term Expires
Frank B. Norbury, Jacksonville, *Chairman*	1988
Donald Aaronson, Chicago	1987
Arthur Fischer, Berwyn	1989
Eugene P. Johnson, Casey	1986
Eugene T. Leonard, Rockford	1985

Responsibilities and Purposes:

The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*
Carl Campanella, Duquoin
Thomas Schrepfer, Havana

Responsibilities and Purposes:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

REPRESENTATIVES TO INA-ISMS JOINT PRACTICE COMMITTEE

Audley F. Connor, Jr., Chicago
Jeffrey Grabenstein, Chicago
Joseph Murphy, Chicago
A. William Schafer, Hinsdale

Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning and (6) identify and address the ensuing problems related to basic role reorganization.

ISMS REPRESENTATIVES TO OTHER GROUPS

Swanberg Foundation, Quincy
Robert R. Hartman, Jacksonville

Liaison to Ill. Soc. of the Amer. Assoc. of Med. Assts.
Robert R. Hartman, Jacksonville

Ill. Interagency Coun. on Smoking and Disease
Charles L. Swarts, Oak Park

Illinois Medical Records Assoc.
Clifton Reeder, Wilmette

MD Committee on Optometry
Joel Kaplan, Chicago

Statewide Cooperating Organizations Committee of the Commission on Children
Gayle Kates, Chicago

Illinois Cancer Council
Peter Friedell, Chicago

Citizens Committee for an Illinois Program to Control High Blood Pressure
David Berkson, Chicago

U.S. Pharmacopaeia
Joseph Skom, Chicago, *Delegate*
Vincent Costanzo, Chicago, *Alternate*

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in this issue. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____ CITY: _____ ZIP: _____

ADDRESS: _____

TELEPHONE: () _____

COUNTY MEDICAL SOCIETY: _____

MEDICAL SPECIALTY AND TYPE OF PRACTICE: _____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602

ISMS SERVICES

Members of the Illinois State Medical Society benefit from a wide range of services, programs, and publications. These are developed in response to official actions and policies of the House of Delegates and implemented through the Board of Trustees. The headquarters staff has been structured to respond to the directives of the House and the Board and develops and coordinates activities to provide these services. Following is a brief description of the divisional structuring, organization and services of the Society and the headquarters office.

EXECUTIVE OFFICE

Mr. Alexander R. Lerner is Executive Administrator of the Society. The Executive Administrator is responsible for the implementation of established policy, fiscal, budgetary and personnel matters. In this position, the Executive Administrator:

- provides liaison with the Board of Trustees and implements their actions
- is responsible for support and staffing of the House of Delegates
- evaluates legal inquiries for appropriate referral to corporate counsel
- has final authority for management team program planning and implementation
- provides guidance to officers, trustees, committee chairmen and county society officers
- directs activity and organization of staff personnel
- serves as secretary-treasurer for the Illinois State Medical Insurance Services, Inc.

Society programs, issues and activities are coordinated administratively through delegation of managerial authority.

ADMINISTRATION

The Deputy Administrator, Administration, directs and manages activities of the Divisions of Medical Education, Specialty Society Services, Administrative Records, and Meeting Services. Additionally, direct staff support is provided through the Deputy Administrator for the House of Delegates, Board of Trustees, Executive Committee, Policy Committee, Constitution and Bylaws Committee, the Educational and Scientific Foundation, the Medical Student Section, the Resident Physician Section, and the Benevolence Fund. Overall provision of services of staff are coordinated through the Deputy Administrator. Various membership benefits are within this management group, including the 50 Year Club, Society-sponsored travel programs and meeting services for ISMS and other groups for which staff services are provided. The Deputy Administrator reports directly to the Executive Administrator and assumes additional responsibility at the direction of the Executive Administrator.

Medical Education

The Society monitors changes in medical education, post graduate requirements for licensure and accreditation procedures. Educational matters are addressed through staff services to the Illinois Council on Continuing Medical Education, the ISMS Council on Education and Manpower and the Committee on CME Accreditation. In addition, staff services are provided to the Task Force on Health Professions, the Task Force on Financial Aid to Medical Students and the Committee on Loss Prevention Education.

Educational matters are addressed through the following services:

- ICCME—The Illinois Council on Continuing Medical Education is jointly sponsored by ISMS and the State's eight medical schools, the purpose of which is to encourage the development of quality CME through formal learning programs, educational consultation and educationally related research.
- Council on Education and Manpower—This Council considers educational issues which affect the medical manpower and licensure needs of Illinois.
- Committee on CME Accreditation—This Committee deliberates on the periodic accreditation status of Illinois CME sponsors and makes accreditation decisions.
- Committee on Loss Prevention Education—This Committee develops educational programs for Illinois physicians on malpractice/loss prevention, and works to publicize the need for organized medicine to reduce exposure to medical malpractice litigation and is responsible for bimonthly publication of the "Antidote" claims flyer.
- Task Force on Health Professions. This Task Force provides a forum for common issues affecting physicians and representatives of health professions who work under close physician supervision.
- Task Force on Financial Aid to Medical Students. This Task Force is responsible for developing and maintaining the ISMS student loan program through the Educational and Scientific Foundation and exploring possible ways to raise funds for the development of the student loan program.
- The Medical Student Loan Fund Program is a joint effort of ISMS and the Illinois Agricultural Association. The Medical Student Loan Fund Board screens students whose college grades or MCAT scores are marginal and recommends special consideration by the UI College of Medicine in selected cases. In return, the student promises to practice in a rural community needing a physician for four or five years after graduation. The program also makes low interest loans available to students.
- A new loan program has been instituted through the ISMS Educational and Scientific Foundation, supported by a dues allocation and other grants. This program was initiated in 1983 through the Task Force on Financial Aid to Medical Students.

Meeting Services and Membership Programs

A number of programs and services are provided to Society members or sponsored for their benefit. These include the 50-Year-Club, physician recruitment, meeting services and travel programs.

- The 50-Year-Club consists of physicians who graduated from medical school more than 50 years ago. An annual luncheon gives these members an opportunity to renew friendships.
- ISMS meeting services include provision of services for assemblies of the House of Delegates and Board of Trustees. Councils and committees meet in the headquarters office.
- Society-sponsored travel programs enable members to enjoy luxury cruises and tours. Qualified tour agencies are screened for professional, non-regimented trips.

Medical students and residents have formed affiliate sections within the Society. ISMS also conducts several programs for new physicians and those seeking either a medical education or an opportunity to practice in Illinois.

- The Physician Recruitment Program seeks to link communities in need of a physician with those seeking practice opportunities.
- The MECO (Medical Education Community Orientation) program seeks to encourage students to select careers in primary care.

Administrative Records

The Division of Administrative Records is charged with responsibility for maintaining the listing of official actions and positions taken by ISMS' House of Delegates and Board of Trustees. The minutes and official transcriptions are maintained by this Division. In addition, records of all appointments and nominations are kept, as well as any other official documents. Staff services are provided the Committee on Committees.

Services to Specialty Societies

Administrative services are provided to specialty societies and affiliated groups on a cost-allocated basis. These include office management, meeting arrangements, membership promotion and record maintenance, newsletter publishing, legislative representation, dues collection and accounting services. Staff services are provided to the Council on Affiliate Societies.

COMMUNICATIONS

Under direction of the Associate Administrator for Communications, the activities of the Divisions of Publications, Medical Services, and Membership/Marketing-Public Relations are coordinated. These divisions work extensively to:

- provide information on a broad range of issues that affect physicians in their practice.
- provide a broad range of information to the media and public on the position of ISMS on important medical issues
- provide consultation and coordination to other ISMS divisions in the area of membership mailings, and distribution of membership information and public relations activities.
- monitoring health care facilities, medical discipline, public and mental health issues and clinical medical issues.
- provide information and service to hospital medical staffs.

Membership/Marketing-Public Relations

The work of the Division of Membership/Marketing-Public Relations is concerned with retention and recruitment of ISMS members; maintaining and increasing contributions to IMPAC and providing information to the media and public to enhance the image of the medical profession. This includes the following activities:

- Field Representation: Field representatives provide service to the members through their work with trustees, county society presidents, secretaries and staff, hospital medical staffs and physicians in clinics.
- President's Tour: The ISMS president visits with county medical society members, informs them of important society activities and takes their members' concerns to ISMS leadership.
- Physician File Maintenance: Communication with the members cannot be accomplished without a sophisticated physician data base. Physician addresses and membership status are updated daily.
- Recruitment: Recruitment of ISMS members is primarily the county medical society's job with assistance from this ISMS division.
- Member, Staff and Media Information: Division staff members provide information and assistance to members, county society presidents and secretaries, ISMS staff, hospital medical staffs, the media and the public about ISMS membership and about any issue of concern to the member. The Division is responsible for providing staff services to the Council on Public Relations and Membership Services and the Committee on Hospital Medical Staffs.

As part of its public relations effort, division staff work to provide information concerning ISMS to the news media and public through such mechanisms as:

- Speeches prepared for ISMS officers, slide presentations and informational brochures;
- News releases publicizing ISMS actions and views;
- Public service announcements produced and distributed to Illinois media to provide valuable health information to the general public.

Publications

Staff of the Division of Publications work to provide information to the ISMS membership through various publications. Services include promotional design and layout, editing and creating for such publications as:

- The *Illinois Medical Journal* which is published monthly to keep members aware of clinical, economic, legal, and political events;
- *Action Report* which is published periodically to inform members of Society activities and present news in the area of socio-economics;
- *On the Legislative Scene* is distributed on request to ISMS members during the General Assembly session to offer a status report on pending legislation of importance to Illinois physicians; and
- *AID (Athletics, Injury and Disease)* offers sports-medicine information to junior and senior high school coaches and trainers in Illinois to help them prevent, recognize and triage sports-related injuries and illnesses.

Society staff also produce publications for ISMS' affiliate groups, including:

- *Pulse of the ISMS Auxiliary,* published quarterly for the ISMS Auxiliary;
- *Antidote*-a loss prevention education flyer for physicians.
- Affiliate group newsletters published for various state specialty societies.

Activities of the Division are directed by the Society's Publications Committee and the *IMJ* Editorial Board. Additional publication production services are provided on a cost-reimbursement shared service basis for subsidiary organizations.

Medical Services

The Division of Medical Services is responsible for initiating, supporting, monitoring and implementing activities related to health care facilities, alcohol and drug misuse, discipline of physicians, public and mental health, physician impairment, medical-legal issues, school and child health, maternal welfare, aging, blood banking, sports

medicine, and emergency medical services. These responsibilities are carried out through the following:

- Council and committee activities, where members and outside consultants examine, debate and formulate ideas and recommendations for consideration by the Board of Trustees;
- Development of educational materials and programs for the physician and his patient;
- Liaison activities with governmental, professional and consumer organizations to promote and defend ISMS policies or concerns and educate others about issues important to physicians.

The following Councils and their Committees are supported by staff of this Division: Committee for the Impaired Physician, Judicial Panel, Medical-Legal Council, Council on Medical Services, Council on Mental Health & Addiction, Peer Review Appeals Committee, Committee on Workers Compensation, Maternal Welfare Committee, Committee on Alcoholism and Drug Dependence, Committee on Sports Medicine, and Committee on Laboratory Services. Ongoing liaison is conducted with various agencies to keep abreast of current developments and items of mutual concern.

In addition, the Division administers a state grant from the new Department of Alcoholism and Substance Abuse to create materials and conduct educational programs on substance abuse throughout 1984-85.

FINANCE AND MANAGEMENT SERVICES

The activities of Finance and Management Services are in the Management Group headed by the Controller. The Controller directs financial management activities, computer services, office services, and personnel management. Liaison is maintained with the various auditing firms and responsibility is taken for management of the physical premises occupied by the Society.

Financial Management

Financial Management services are conducted under policies established by the Board of Trustees and Finance Committee. These activities include financial reporting, maintaining financial records for receipts and disbursements, budgeting, monitoring investments and securing assets.

Computer Services

As an integral part of financial management, electronic data processing capabilities are maintained to provide a cost-effective method to:

- Maintain membership and policyholder records.
- Provide central Society dues billings and collection for county medical societies.
- Provide invoicing for professional liability premiums.
- Maintain records and statistics on professional liability claims, policyholder files and other insurance related information.
- Process financial records.
- Provide word processing capabilities.

Office Services

Office services includes building services for staff and physician meetings, mail and supply services, switchboard and receptionist services for the Society and Insurance operations. Facility maintenance, telephone service and centralized purchasing are also under the office service function.

Personnel

Staffing for the Society is centralized under Personnel for recruiting, payroll, employee benefits, employee counseling and training and maintenance of personnel records

Sponsored Insurance Programs

Staff services are provided for the ISMS Insurance Committee which works through an independent broker as directed by the Board of Trustees, in sponsoring various insurance programs for the benefit of the membership. Each program has been scrutinized for quality and economy. A brief synopsis of each program follows:

Group Term Life Insurance

The group term life insurance program is underwritten by the North American Company for Life and Health Insurance. It offers:

- $25,000 to $1 million in level term life insurance
- a built-in waiver of premium
- availability to members, their spouses and employees under age 65
- coverage to $5,000 for members' children
- non-cancellable, guaranteed renewability to age 100
- conversion to permanent individual policy guaranteed to age 65

Group Disability Income Protection Program

The group disability income protection program is underwritten by the Commercial Insurance Company. It provides:

- $500-$3,000/month for total disability
- coverage renewable to age 70
- benefit period options of lifetime accident and sickness
- payable (1) to age 65; (2) for seven years; (3) five year accident and sickness payable for 2 years
- available to members and authorized employees or insured members to age 55
- benefits payable regardless of other insurance
- no restrictive riders attached after issuance
- individual coverage cannot be terminated

Professional Overhead Expense Plan

This plan is underwritten by the Hartford Accident and Indemnity Company and provides:

- $500-$5,000/month coverage
- office overhead expenses paid to maximum benefit selected beginning with 31st day of total disability
- benefits payable to 24 months regardless of other insurance
- accumulation benefit provided
- guaranteed issue for qualified new members under age 40 who apply within 60 days of effective date of membership
- available to all members under age 65 in full time practice
- rent, utilities, employee salaries and monthly *pro rata* of specified annual fixed expenses customary to the profession
- premiums deductible for individuals and partnerships under Revenue Ruling 55-264

The plan does not cover personal income, salaries for other physicians, principal payments on debts, implements, pharmaceutical products and personal insurance premiums.

Group Major Medical

The group major medical plan is underwritten by Commercial Insurance Company. It provides that the insured select a calendar

year deductible of $500, $1,000 or $2,000 which applies to each insured person. It will then pay 80% of reasonable and customary expenses such as:

- semi-private room in the hospital
- hospital supplies and services, physician services, anesthetists, diagnostic lab and X-ray, registered nurses, ambulance services, prescription drugs and medicines, physiotherapy, therapeutic equipment rentals, artificial limbs, oxygen and blood.

The plan has a maximum out-of-pocket expense of $4,000 plus deductible and pays up to a lifetime maximum of $500,000 on health benefits. The plan is available to all members and qualified employees of insured members under age 55, and can be renewed up to age 65.

Medicare Supplement

The Medicare supplement plan is underwritten by the Hartford Accident & Indemnity Company. It covers charges for the following, incurred either as in-patient or out-patient:

- annual Medicare deductibles
- semi-private room and board
- diagnostic X-rays, lab tests, doctor's services, general nursing, drugs, anesthesia and many other hospital, medical and surgical services which are partially covered by Medicare.

The plan is available to members 65 and over and once members are enrolled, their spouses may be insured on reaching age 65. Eligible applicants are guaranteed acceptance subject to a pre-existing condition limitation.

Hospital Indemnity Plan

The Hartford Accident and Indemnity Company underwrites the ISMS-sponsored hospital indemnity plan. Available plans provide benefits of $27.50, $55.00, $110.00 or $165 per day of hospital confinement. Benefits are also:

- initiated with first day of confinement
- payable to 365 days for each cause of confinement
- automatically doubled for hospital stays due to cancer or confinement in an ICU for persons under age 65
- payable regardless of other insurance

All members, their employees and families may participate. Acceptance of eligible applicants during special enrollment periods is guaranteed, subject to a pre-existing conditions limitation.

Workers' Compensation

Policies issued by the Casualty Reciprocal Exchange, a member of the Dodson Insurance group, are administered under the Dodson Savings Plan. Specific aspects include the following:

- return declared at the end of each premium year on the basis of loss experience—savings are returned to policyholders
- rates standard and approved for class of employment
- savings paid as earned within approximately 90 days of policy expiration or on completion of payroll audits

Accidental Death and Dismemberment

An accidental death and dismemberment plan is underwritten by the Hartford Accident & Indemnity Company. It provides coverage:

- for members, their spouses, children and employees
- a 24-hour business and pleasure coverage from $25,000 to $250,000
- renewable to age 70

GOVERNMENTAL AFFAIRS

The Division of Governmental Affairs, under direction of the Assistant Administrator for Governmental Affairs, provides staff services for the Governmental Affairs Council, Public Affairs Committee, IMPAC, and liaison to various governmental agencies. The Society's legislative program is conducted under direction of the Governmental Affairs Council. All state and national health legislation is monitored. Society staff forward bills to physician members with pertinent expertise for review and comment. Legislative representatives express the ISMS position to legislators, while also continually monitoring amendments to bills of interest to the medical profession. The Division also coordinates physician testimony before legislative committees.

Additional input and citizen involvement are developed through the Key Contact Program and public affairs activity.

- The Key Contact Program is a network of physicians or spouses who are relatives, friends or campaign supporters of Illinois legislators, in order to advise legislators on health legislation.
- Public Affairs activity includes sponsorship of speakers at Society meetings and liaison with government agencies. It encourages grassroots involvement in the political process. Also, the Division coordinates activities of the Illinois State Medical Society Political Action Committee.

Staff services are provided through both the Chicago headquarters and the Springfield Regional Office.

HEALTH CARE FINANCE

The Division of Health Care Finance concerns itself primarily with economic issues facing the profession. Staff services are provided the Council on Economics, the Committee on Health Planning, the Third Party Payment Processes Committee, and the Committee on Drugs and Therapeutics. The Division is under the direction of the Assistant Administrator for Health Care Finance. Under the direction of the Board, various services are provided to members with questions or problems in the following aspects of health care finance:

- Medicaid, Medicare & CHAMPUS—Services are provided in representation of member interests of a policy nature. Liaison is provided with Illinois Department of Public Aid and the Medicare Part B carrier to assure that member concerns are represented when policy changes are considered. Specific assistance is provided for members being audited.

- Health Planning—Actions of Statewide Health Coordinating Council, Illinois Health Facilities Planning Board (CON), and local Health Systems Agencies are closely monitored and Society positions are expressed.
- Third Party Payor and Economic Activity—The Division is directly involved in liaison activities with insurance carriers and government bodies on all economic issues relating to the practice of medicine, *e.g.*, hold harmless agreements and determinations of medical necessity. The Division performs research, offers speakers and monitors the development of new reimbursement and health care delivery systems for the membership, *e.g.*, Diagnosis Related Groups (DRGs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Utilization Review (Private and Peer Review Organizations [PROs]) and HMOs/IPAs.
- Cost containment activities—Various cost containment concerns are monitored, such as the Illinois Cost Containment Council, Hospital Service Procurement Advisory Board, to assure appropriate medical issues are included.
- Health Data Systems—Government requirements for statistical information on health care and planning are monitored.
- Drugs and Therapeutics—The Division provides staff assistance to the ISMS Committee on Drugs and Therapeutics, which reviews new drug products and makes recommendations on products for inclusion in the IDPA Drug Manual for Public Aid recipients.

DIRECTORY OF MANAGEMENT STAFF PERSONNEL

The Illinois State Medical Society headquarters office is located at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602. The telephone number is (312) 782-1654. In addition, a Springfield office is maintained at 702 South Second Street, Springfield, Illinois 62704, telephone (217) 528-5609.

Below are the key staff identified by managerial areas in keeping with the above itemization of responsibilities. Following the name of the individual is a direct dial telephone number at the headquarters office. Any staff member can also be reached through the general information number (312) 782-1654.

EXECUTIVE OFFICE

Alexander R. Lerner, Executive Administrator 580-2412

ADMINISTRATION

Richard A. Ott, Deputy Administrator 580-2460

Perry L. Smithers, Executive Assistant 580-2416

Thomas Pearson, Ed.D., Director, Medical Education 580-2445

Kathleen A. Pirages, M.S.Ed., Assistant Director, Medical Education ... 580-2481

Elizabeth Duffy, Director, Meeting Services and Membership Programs 580-2472

Rose Anne Christiansen, Director, Administrative Records 580-2470

Mary Szymanski, Assistant Director, Specialty Society Services 580-2459

COMMUNICATIONS

Donald Udstuen, Associate Administrator 580-2418

Linda Hudson, Director, Division of Membership/Marketing Public Relations 580-2449

Gary Fitzgerald, Assistant Director, Field Services 580-2474

Martin Masel, Field Representative 580-2473

Edward Stecki, Director, Division of Publications 580-2456

Mariann Stephens, Assistant Director, Publications 580-2419

Larry Boress, Director, Division of Medical Services 580-2435

FINANCE AND MANAGEMENT SERVICES

Lawrence Deidrick, Controller 580-2420

James Giese, Assistant Director, Finance 580-2454

Diana Role, Assistant Director, Computer Services 580-2488

Robert Yocum, Director, Office Services 580-2401

Deborah Simpson, Assistant Director, Personnel 580-2430

Alan Allphin, Internal Auditor 580-2432

GOVERNMENTAL AFFAIRS

Jeffrey M. Holden, Assistant Administrator, Governmental Affairs 580-2440

James Tierney, Assistant Director 580-2484

Springfield Regional Office 217/528-5609

HEALTH CARE FINANCE

Robert K. Burger, Assistant Administrator, Health Care Finance 580-2462

Ken Ryan, Assistant Director, Health Care Finance 580-2491

Illinois State Medical Society Auxiliary

The Illinois State Medical Society Auxiliary is a unique organization composed entirely of physicians' spouses who give their time and talents to promote health awareness, medical legislation and funds for medical research and education, including the American Medical Association Education and Research Foundation (AMA-ERF).

The Illinois State Medical Society Auxiliary had its inception in the parlor car of a speeding train in 1927. Dr. and Mrs. G. Henry Mundt were returning from the AMA meeting in Washington, D.C. and had learned of the existence of the AMA Auxiliary and of 22 functioning state auxiliaries. Mrs. Mundt was persuaded to undertake the task of organizing an auxiliary in Illinois and to seek the approval of the Illinois State Medical Society's House of Delegates. On May 31, 1927, the ISMS House of Delegates endorsed the organization of an auxiliary in Illinois and urged the county societies to assist in promoting auxiliary membership.

The first formal meeting of the auxiliary was held at the LeClaire Hotel in Moline on June 2, 1927 with 25 members present. In 1928, the organization became permanent. Today, we have a membership of over 3100 and can look with pride on the auxiliary's accomplishments.

The auxiliary has instituted a large number of successful community health programs (*e.g.*, Vial of Life, Nutrition, Physical Fitness, Stress Management, Child Seat Belt Safety, Immunization and Substance Abuse Awareness). We have striven to educate the public on cost effective use of the medical care system and we have been highly successful in fund raising to provide financial assistance to medical students and medical schools.

Although we can look with pride upon what we have done, there is much that remains to be accomplished. For example, we will be increasing our fund raising activities for medical education and research. Volunteer organizations such as ours will be assuming a primary role in dealing with society's health problems. Greater emphasis will be placed on supportive programs addressing current concerns such as malpractice that affect the medical family. We must work to convince other physician spouses that participating in Auxiliary activities is a worthwhile investment of time. Greater involvement with spouses of medical students and residents is encouraged through the SASII program (Sponsor A Spouse In Illinois). On the legislative scene, we provide information on health-related legislation, are a part of a legislative alert system and engage in face-to-face contact with legislators.

We recognize that it is our responsibility to provide leadership education for our up and coming county, state and national leaders. Thus, the inception of the State Leadership Conferences and participation in the AMA Auxiliary Confluence in October for county presidents-elect. We use our "PULSE" publication to communicate with the membership.

We are also concentrating our efforts on a closer working relationship with ISMS, as together, we meet the challenges of medicine in the '80's.

Officers

President
Mrs. Robert Reardon, Bloomington
President-Elect
Mrs. Thomas Meirink, Belleville
1st Vice-President
(Membership Coordinator)
Mrs. Paul Stanley, Decatur
2nd Vice-President
(Program and Project Bank Coordinator)
Mrs. Gene Hoerr, Peoria
3rd Vice-President
(Health Projects Coordinator)
Mrs. J.D. Winterhalter, Jacksonville
Secretary
Mrs. Alex J. Spadoni, Hinsdale
Treasurer
Mrs. Wayne Kassel, Joliet

Directors

Mrs. Selig Hodes, Forreston
Mrs. Walter Stevenson, Quincy
Mrs. Robert Webb, Edwardsville

Parliamentarian

Mrs. Harlan Failor, Champaign

District Councilors

1. Mrs. Charles VanGorder, Geneva
2. Mrs. James Wilson, Princeton
3. Mrs. Gustavo Bermudez, Chicago
4. Mrs. John McLean, Peoria
5. Mrs. Wesley Betsill, Springfield
6. Mrs. Norman Taylor, East Alton
7. Mrs. Herbert Thompson, Decatur
8. Mrs. Mack Hollowell, Charleston
9. Mrs. James Chow, Mt. Vernon
10. Mrs. W. A. Simmons, Belleville
11. Mrs. John Simonaitis, Elmhurst
12. Mrs. Raymond Hoffman, Rockford

Committee Chairmen

AMA-ERF
Mrs. Allan Minster, Lake Forest
Archives
Mrs. Alex Spadoni, Hinsdale
Benevolence
Mrs. Walter Stevenson, III, Quincy
Boutique Coordinator
Mrs. Selig Hodes, Forreston
Boutique Ass't.
Mrs. William Hodges, Kankakee
Bylaws
Mrs. Harlan Failor, Champaign
Convention Co-Chairmen
Mrs. John Krueger, Normal
Mrs. John Randolph, Bloomington
Directory
Mrs. Robert Webb, Edwardsville
Drinking & Driving
Mrs. W. G. Thielemann, Carlock
Editor
Mrs. Philip Hays, Kankakee
Fall Conference
Mrs. Frederick Haynes, Champaign
Finance
Mrs. Robert Webb, Edwardsville
Health Projects Coordinator
Mrs. J. D. Winterhalter, Jacksonville
Humanitarian
Mrs. Gene Hoerr, Peoria
Immunization
Mrs. John Leyland, East Peoria
International Health
Mrs. Wesley Betsill, Springfield
Interstate Conference with Wisconsin
Mrs. Raymond Hoffmann, Rockford
Kindergarten-Teens
Mrs. Richard L. Newman, Quincy
Later Years
Mrs. J. D. Winterhalter, Jacksonville
Legislation
Mrs. Alan Taylor, Danville
Long Range Planning
Mrs. Thomas Meirink, Belleville
Membership Coordinator
Mrs. Paul Stanley, Decatur
Members-at-Large
Mrs. Gilbert Blaum, Lincoln
Physicians' Spouse Support Team Malpractice
Mrs. R. Samuel Hoover, Lake Forest
Program & Project Bank
Mrs. Gene Hoerr, Peoria
Public Relations
Mrs. G. Richard Locke, Decatur
RP/MSS Liaison
Mrs. Edward Kwedar, Springfield
Widows & Spouses of Retired Physicians
Mrs. Earl Klaren, Libertyville

Consultants

AMAA Liaison
Mrs. Edward Szewczyk, Belleville
Mrs. Don Hinderliter, Rochelle
Cults
Mrs. George Olander, Lake Forest
Exceptional Person Awareness
Mrs. Gene Hoerr, Peoria
Grief & Bereavement
Mrs. Donald Fisk, Galesburg

Parenting
Mrs. Don Hinderliter, Rochelle
Scrapbook
Mrs. August Martinucci, Joliet
Seat Belt Safety
Mrs. Ronald Severino, Wheaton
Stress
Mrs. Jerry Beguelin, Irvington

Representatives to ISMS Councils and Committees

Alcoholism and Drug Dependence
Mrs. Wayne Kassel, Joliet
Benevolence
Mrs. Louis Tarsinos, Princeton
Mrs. Walter Stevenson, Quincy
Governmental Affairs
Mrs. Alan Taylor, Danville
Health Planning
Mrs. J. D. Winterhalter, Jacksonville
Medical Services
Mrs. Selig Hodes, Forreston
Mental Health & Addiction
Mrs. Alex Spadoni, Hinsdale
Public Relations & Membership Services
Mrs. Paul Stanley, Decatur
Sports Medicine
Mrs. Harold Keegan, Kankakee
Task Force on Financial Assistance to Medical Students
Mrs. Don Hinderliter, Rochelle

Representatives to Outside Groups

Illinois Commission on Children and Youth
Mrs. Robert Reardon, Bloomington
Illinois Interagency Council on Smoking and Disease
Mrs. John Simonaitis, Elmhurst

American Association of Medical Assistants, Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending medical assistant programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are: travel courses, regional seminars, annual symposium, personal development day and the all day workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The annual three day meeting in April includes excellent lectures, study programs and the culmination of association business during the house of delegates session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this program contact the American Association of Medical Assistants, 20 North Wacker Drive, Chicago IL 60606.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with over 500 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (*i.e.,* group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (Downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), West Cook (River Grove), Cook County South (Oak Forest), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), LaSalle, Macon (Decatur), McLean (Bloomington), Peoria, Randolph (Chester), Rock Island-Moline, St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will Grundy (Joliet) and Winnebago (Rockford). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact: Anna Cannon, 7443 Luella, Chicago IL 60649 or Betty Kronemeyer, CMA, 809 N. 10th St., Mascoutah IL 62258.

Officers

President: Anna Cannon, Chicago
President-Elect: Ehlma Garcia, CMA-EMT, Chicago
Immediate Past President: Betty J. Kronemeyer, CMA, Mascoutah
1st Vice President: Cheryl Hutchison, CMA, Granite City
2nd Vice President: Betty Jean Meier, DeKalb
Recording Secretary: Jean Walsh, Chicago
Membership Secretary: Jewel Nelson, Chicago
Corresponding Secretary: Mary Francis Dunham, MT, Chicago
Treasurer: Dolores Dupree, Berwyn
Speaker of the House: Jean Fouts, LPN, Normal
Vice Speaker: A. Ruth Thompson, CMA, Decatur
Board of Trustees, Chairman: Mary Lu Ostrowski, CMA, Bloomington
Parliamentary Advisor: Florence Perry, CMA, Chicago
Chaplain: Darlene Van Dyke, Westchester
Historian: Rosemarie Ponce, Chicago
Photographer: Stella Krystyniak, Norridge

Physician Advisors

John L. Wright, M.D., Bloomington, *Chairman*
Jack Chandler Berger, M.D., Chicago
Robert R. Hartman, M.D., Jacksonville, ISMS Liaison, AAMA Advisor
T. R. Harwood, M.D., Chicago
Peter C. Lee, M.D., Granite City
Leslie Schwartz, M.D., Chicago
Robert E. Thompson, M.D., Peoria

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

Board of Directors

Robert P. Johnson, Springfield, *Chairman*
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago
Alfred J. Kiessel, Decatur
Morgan M. Meyer, Lombard

Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in cooperation with the state's eight medical schools, to fulfill these purposes: (a) encourage and assist in the development of continuing medical education programs for Illinois physicians that will enhance patient care; (b) study and encourage development of new educational methods, techniques, systems, *etc.;* (c) assist learning sources to identify the educational needs of Illinois physicians; and (d) stimulate, motivate, and encourage physicians at all levels throughout the state to participate in formal continuing educational programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as chairman of the organizing committee.

ICCME was officially chartered by the state as a nonprofit educational organization in May, 1972, and began operations in September, 1972. Financial support of the Council is provided primarily by ISMS members' dues.

ICCME unites the resources of the Illinois State Medical Society and the educational resources of the state's medical schools; it serves *all* interests concerned with CME and thus provides a crucial channel of communication to coordinate the efficient use of all available resources.

Current Major Activities

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois healthcare system in the Council's work.
2. On behalf of ISMS, perform site visits for accreditation of intrastate CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME planning and organization.
4. Organize workshops on techniques of CME—including an unusual "Seminar on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. For all items now available, request "The Illinois Handbook on CME Planning — Catalog/Order Form." All publications are available to ISMS members at a 50% discount. To obtain a copy of the Catalog/Order Form just indicate this on your prescription form and mail to ICCME, Twenty North Michigan Ave.; Suite 700, Chicago, Illinois 60602.
6. Prepare a monthly calendar of Illinois CME activities for *IMJ.*
7. Plan and conduct research studies that contribute to the improvement of CME methods.

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of nine practicing physicians representing the State Medical Society and eight academic physicians/educators, one selected by each dean of an Illinois medical school.

Board of Directors

Harold A. Paul, M.D., M.P.H., *President*
Robert L. Prentice, M.D., *Vice-President*
Michael H.M. Dykes, M.D., M.Ed., *Secretary*
Lawrence L. Hirsch, M.D., *Treasurer*
Ben B. Blivaiss, Ph.D., North Chicago
Dean R. Bordeaux, M.D., M.A., (Educ.), Peoria
Ernesto B. Eusebio, M.D., Springfield
Linda K. Gunzburger, Ph.D., Maywood
Terry F. Hatch, M.D., Urbana
Marten M. Kernis, Ph.D., Chicago
Thomas P. Meirink, M.D., Belleville
Julius S. Newman, M.D., Aurora
Charles E. Osborne, Ed.D., Springfield
Ward E. Perrin, D.O., F.A.C.O.I., Chicago
Donald F. Pochyly, M.D., M.Ed., Hines
Francis H. Straus, II, M.D., Chicago
Cyril C. Wiggishoff, M.D., Chicago

Panel of Accreditation Site Visit Surveyors

Serving as Surveyors are Board Members of the Illinois Council on Continuing Medical Education and others chosen by the ICCME Board who meet criteria adopted by the ISMS Board of Trustees, March 31, 1979. ICCME does *not* make accreditation decisions, neither individual Board Members nor the Board collectively. Rather, the Survey Team's role is analogous to that of the physician who performs a physical examination on a potential purchaser of life insurance: to ascertain and report the facts, leaving to the underwriter the actuarial decision on granting insurance. The Survey Team makes a judgment on each of the seven "Illinois Criteria," on the basis of point values prescribed by the ISMS Committee on CME Accreditation, as well as the Team's conversation with the Sponsor. Individuals serving on the Panel of Surveyors, in addition to members of the ICCME Board, are shown at the top of page 267 (all are physicians unless otherwise indicated):

Philip D. Anderson, M.D., Ph.D.
Anthony L. Barbato
Lloyd Barr, Ph.D.
Ernst Chester Bone
Bradford W. Claxton, M.Ed.
Alfred J. Clementi
Joseph L. Daddino
John G. Demakis
Richard E. Dukes
Sherman Elias
L. Penfield Faber
Charles G. Farnum, Jr.
Peter O. Fried
Allan L. Goslin
Robert C. Hamilton
Robert R. Hartman
Henri S. Havdala
Thomas O. Henderson, Ph.D.
Eugene T. Hoban
John M. Holland
Kathryn S. Huss
Ross N. Hutchison
William L. Jackson
Frank J. Jirka, Jr.
Eugene P. Johnson
Alfred J. Kiessel
James M. Laidlaw
Howard B. Levy
Paul A. Maxwell, Jr.
Boyd E. McCracken, Sr.
Morgan M. Meyer
Joseph R. O'Donnell
Joseph B. Perez
Mather Pfeiffenberger
Eugene Scherba
Joseph C. Sherrick
George Shropshear
Robert C. Stepto
Jacob R. Suker
L. W. Tanner
Sheldon S. Waldstein
Charles J. Weigel
Ruth Wharton
Fred Z. White, M.D., M.A.
George T. Wilkins
Roger A. Wujek

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with the Regional Health Resources Center, Urbana, Illinois for administrative services.

IFMC Board of Directors

Joseph Sherrick, Chicago, *President*
Robert P. Johnson, Springfield, *Vice-President*
James Laidlaw, Champaign, *Secretary-Treasurer*
Audley F. Connor, Jr., Chicago
Morris T. Friedell, Chicago
Lawrence L. Hirsch, Chicago
Robert Prentice, Springfield

Illinois State Medical Society Political Action Committee (IMPAC)

The Illinois State Medical Society Political Action Committee will celebrate its 25th year as a leader in medical politics in 1985. IMPAC is a voluntary non-profit, unincorporated, permanent membership organization. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his/her spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U.S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Twenty North Michigan Avenue, Suite 700, Chicago 60602.

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services, Inc. is an Illinois corporation, formed in March 1976, the capital stock of which is owned by the Illinois State Medical Society. It currently acts as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Inter-Insurance Exchange was organized as an insurance reciprocal to provide comprehensive professional liability insurance for Illinois physicians. Membership in the Exchange is limited to members of the Illinois State Medical Society. The Exchange is chartered under the laws of Illinois and functions under the Illinois Insurance Code.

Insurance Services provides management and underwriting services required for operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement and by each member of the Exchange through application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business. Within these policy guidelines Insurance Services provides management by accepting or rejecting applications, determining the form of insurance policies, and handling and disposing of claims. Insurance Services is compensated by the Exchange on the basis of expense reimbursement.

As a wholly-owned subsidiary, ISMIS provides certain services through ISMS on a shared basis. These shared services are on a direct cost reimbursement basis. Insurance Services itself includes four principal divisions: Underwriting, Claims, Medical Director and Administrative Services. In addition, shared services support is provided by ISMS through the Divisions of Administration, Marketing-Public Relations, Publications, Education, Governmental Affairs, Computer Services, Personnel, Finance and Accounting.

Offices of Illinois State Medical Insurance Services, Inc. are at Twenty North Michigan Avenue, Suite 700 Chicago, Illinois 60602 (312/782-2749).

Board of Directors

Warren D. Tuttle, M.D. *Chairman*
Phillip D. Boren, M.D.
Alfred J. Clementi, M.D.
Robert C. Hamilton, M.D.
J.M. Ingalls, M.D.
Clifton L. Reeder, M.D.,

Officers

Warren D. Tuttle, M.D., *Chairman and Chief Operating Officer*
Alexander R. Lerner, *Secretary-Treasurer*
Henry Nussbaum, *Vice President*

Resident Physicians Section

Michael Nieder, Chairman
Michael Davidson, Vice Chairman
James Scruggs, Secretary
Charles Cattano, Delegate
Linda Brubaker, Alternate Delegate

Council Representatives

John Diveris, Education & Manpower
Michael Reirmaier, Medical Services
Lois Margaret Nora, Medical-Legal
Mark Ridlen, Public Relations & Membership Services
Frank Pieri, Mental Health & Addiction
James W. Scruggs, Economics
Patrick Stodola, Governmental Affairs

Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its Constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

Medical Student Section

Richard E. Terek, Chairman
Nancy Zamora, Vice Chairman
Thomas Zusag, Secretary
Karen Kawala, Delegate
Gail Herman, Alternate Delegate
Lauren Baker, MECO Coordinator

School Representatives

Chicago Medical School
Michael Oberlander
Loyola University
John Kall
University of Illinois College of Medicine*
Chicago Campus—
1853 W. Polk Street, Chicago, 60612
University of Illinois-Chicago
Gail Herman
University of Illinois-Champaign/Urbana
Hal Bennett
University of Illinois-Peoria
Vacancy
University of Illinois-Rockford
Nancy Zamora
Chicago College of Osteopathic Medicine
Vacancy
Northwestern University
Gregory M. Gullahorn
Rush Medical College
Lauren Baker
Southern Illinois University
Scott Green
University of Chicago
David Margolis

Council Representatives

Alan J. Scharrer, Education & Manpower
Thomas Zusag, Economics
Michael Kochman, Public Relations
David Margolis, Medical Services
Ronald Shouten, Medical-Legal
David O'Brien, Mental Health & Addiction
Mark Dobbertien, Governmental Affairs

Responsibilities and Purposes

The purposes of the Medical Student Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Medical Student Section shall support the purposes of ISMS as stated in its Constitution. The Medical Student Section is composed of all student members of ISMS.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago College of Osteopathic Medicine
5200 S. Ellis Ave., Chicago 60615
Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153
Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611
Rush Medical College
1725 W. Harrison St., Chicago, 60612
Southern Illinois University School of Medicine
801 N. Rutledge, P.O. Box 3926, Springfield, 62708
University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago, 60637
University of the Health Sciences/The Chicago Medical School
3333 Green Bay Road, North Chicago, IL 60064
University of Illinois College of Medicine*
Chicago Campus—
1853 W. Polk Street, Chicago, 60612

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine and the School of Basic Medical Sciences (Urbana).

ALLIED HEALTH EDUCATION PROGRAMS

Accredited by the American Medical Association Committee on Allied Health Education and Accreditation

Cytotechnologist

CHICAGO—Michael Reese Hospital & Medical Center
University of Chicago—Lying-in-Hospital

Diagnostic Medical Sonographer

OAK LAWN—Christ Hospital

Electroencephalographic Technologist

SPRINGFIELD—St. John's Hospital

Emergency Medical Tech-Paramedic

JOLIET—Silver Cross Hospital

Histologic Technician

CHICAGO—Holy Cross Hospital
St. Joseph Hospital
University of Chicago Lying-In Hospital

PEORIA—St. Francis Hospital and Medical Center
Methodist Medical Center of Illinois

SPRINGFIELD—Memorial Medical Center
St. John's Hospital

Medical Assistants

BELLEVILLE—Belleville Area College

CARTHAGE—Robert Morris College

PALATINE—William Rainey Harper College

RIVER GROVE—Triton College

Medical Laboratory Technician

BELLEVILLE—Belleville Area College

CHICAGO—Malcolm X College

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

GODFREY—Lewis & Clark Community College

GRAYSLAKE—College of Lake County

KANKAKEE—Kankakee Community College

PALOS HILLS—Moraine Valley Community College

QUINCY—Blessing Hospital

RIVER GROVE—Triton College

Medical Record Administrators

CHICAGO—Chicago State University
University of Illinois at Chicago

NORMAL—Illinois State University

Medical Record Technician

BELLEVILLE—Belleville Area College

CHICAGO—Truman College

DES PLAINES—Oakton Community College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

PALOS HILLS—Moraine Valley Community College

Medical Technologist

ARLINGTON HTS.—Northwest Community Hospital

BELLEVILLE—St. Elizabeth Hospital

BLUE ISLAND—St. Francis Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Holy Cross Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Michael Reese Hospital & Medical Center
Rush-Presbyterian-St. Luke's Medical Center
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
University of Illinois at Chicago Hospital

DANVILLE—Lakeview Medical Center

DECATUR—Decatur Memorial Hospital
St. Mary's Hospital

EVANSTON—Evanston Hospital

FREEPORT—Freeport Memorial Hospital

HINES—Edward Hines Jr. V.A. Hospital

HINSDALE—Hinsdale Sanitarium & Hospital

JOLIET—St. Joseph Hospital

MAYWOOD—Foster G. McGaw Hosp./Loyola University

NORTH CHICAGO—University of Health Sciences/Chicago Medical School

OAK LAWN—Christ Hospital

OAK PARK—West Suburban Hospital Association

PARK FOREST—Governors State University

PARK RIDGE—Lutheran General Hospital

PEORIA—Methodist Medical Center of Central Illinois
St. Francis Hospital and Medical Center

QUINCY—St. Mary's Hospital

ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital and Medical Center
Swedish American Hospital

SPRINGFIELD—St. John's Hospital
Sangamon State University

URBANA—Carle Foundation Hospital

WAUKEGAN—St. Therese Hospital

Nuclear Medicine Technology

CHICAGO—Illinois Masonic Medical Center
Northwestern Memorial Hospital

GLEN ELLYN—College of DuPage

HINES—Edward Hines Jr. VA Hospital

OAK LAWN—Christ Hospital

PEORIA—St. Francis Hospital-Medical Center

RIVER GROVE—Triton College

Occupational Therapist

CHICAGO—Chicago State University
University of Illinois at Chicago Hospital

Perfusionist

CHICAGO—Mt. Sinai Hospital Medical Center

Radiation Therapy Technologist

CHICAGO—Chicago State University
Michael Reese Hospital/City Wide College

ELGIN—St. Joseph Hospital

EVANSTON—National College of Education

HINES—Edward Hines Jr. VA Hospital

ROCKFORD—SwedishAmerican Hospital

Radiographer

ARLINGTON HTS.—Northwest Community Hospital

BELLEVILLE—Belleville Area College

CARBONDALE—Southern Illinois University

CENTRALIA—Kaskaskia Junior College

CHAMPAIGN—Parkland College

CHICAGO—Cook County Hospital
DePaul University
Henrotin Hospital
Illinois Masonic Medical Center
Malcolm X College
Ravenswood Hospital Medical Center
St. Joseph Hospital
South Chicago Community Hospital
University of Illinois at Chicago Hospital
Wilbur Wright College

DANVILLE—Lake View Medical Center

DECATUR—Decatur Memorial Hospital

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

ELGIN—St. Joseph Hospital

EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

HINSDALE—Hinsdale Sanitarium & Hospital

KANKAKEE—Kankakee Community College

MACOMB—McDonough District Hospital

MALTA—Kishwaukee College

MOLINE—Black Hawk College/Lutheran Hospital
Moline Public Hospital

NORMAL—Brokaw Hospital

OLNEY—Richland Memorial Hospital

PALOS HILLS—Moraine Valley Community College

PEORIA—St. Francis Hospital Med. Center

QUINCY—Blessing Hospital
St. Mary's Hospital

RIVER GROVE—Triton College

ROCKFORD—Rockford Memorial Hospital
SwedishAmerican Hospital

ROCK ISLAND—Franciscan Medical Center

SOUTH HOLLAND—Thornton Community College

SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

Respiratory Therapist

CARBONDALE—Southern Illinois University

CHAMPAIGN—Parkland College

CHICAGO—Malcolm X College
Northwestern University
University of Chicago Lying-In Hospital

MOLINE—Black Hawk College/Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

ROCKFORD—Rock Valley College

SPRINGFIELD—Lincoln Land Community College

Respiratory Therapy Technician

BELLEVILLE—Belleville Area Jr. College

CHICAGO—Illinois Masonic Medical Center
Marion Adult Ed. Career Trng. Ctr., Inc.
South Chicago Community Hospital

GLEN ELLYN—College of Dupage

KANKAKEE—Kankakee Community College

MOLINE—Black Hawk College/Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

ROCKFORD—Rock Valley College

SPRINGFIELD—St. John's Hospital

WAUKEGAN—Victory Memorial Hospital

Specialist in Blood Bank Technology

CHICAGO—Michael Reese Hospital and Medical Center
Mid-Amer RC Blood Srvs/C. Hymen Blood Center
University of Illinois at Chicago Hospital

PARK RIDGE—Lutheran General Hospital

Surgical Technologist

BELLEVILLE—Belleville Area College

CENTRALIA—Kaskaskia Junior College

CHAMPAIGN—Parkland College

EAST PEORIA—Illinois Central College

MOLINE—Moline Public Hospital

QUINCY—Blessing Hospital

RIVER GROVE—Triton College

ROCKFORD—Swedish-American Hospital

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

Election of senators and representatives is determined in the apportioned districts throughout the state. One senator is elected from each of the 59 districts. Each Senate district contains two House districts. Members of the House of Representatives are elected from these 118 single member House districts.

The General Assembly convenes each year on the second Wednesday of January. The General Assembly is a continuous body during the two year term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. The committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They are elected every four years.

STATE OFFICERS 1984

Governor, James R. Thompson, Rep., Chicago
Lieutenant Governor, George H. Ryan, Rep., Kankakee
Secretary of State, Jim Edgar, Rep., Charleston
Comptroller, Roland W. Burris, Dem., Chicago
Treasurer, James H. Donnewald, Dem., Breese
Attorney General, Neil F. Hartigan, Dem., Chicago

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading, when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (60 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the governor for his consideration.

If the governor thinks the bill should become a law, he will sign it. If the governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each house can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The governor may also return a bill to the legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available at no cost to ISMS members. Also available are four-color maps which detail the boundaries of the Illinois legislative districts. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

Department of Alcoholism and Substance Abuse

300 N. State Street, Chicago 60610, Phone: 312/822-9860
300 W. Monroe Street, Springfield 62706, Phone: 217/782-0686

The Illinois Department of Alcoholism and Substance Abuse is the state agency responsible for the public administration and funding of alcoholism and other drug abuse education, treatment, rehabilitation and prevention programs. The Department is responsible for administration of the Illinois triplicate prescription program for designated product controlled substances, scheduling of controlled substances, licensure for drug abuse programs and controlled substances research, training, and administration of initiatives for special populations and a wide variety of demonstration projects. The Department maintains administrative offices in Springfield and Chicago, and regional offices in Springfield, Chicago, Rockford and Mt. Vernon.

Administrative Staff

Daniel W. Behnke, Deputy Director
Roalda J. Alderman, Associate Director for Policy Development and Implementation
Barbara Frazin-Weiner, Chief Counsel and Legislative Liaison
Patricia J. Larsen, Associate Director for Communications and Public Liaison
J.B. Bixler, Administrator, Division of Technology Transfer
Louis S. DiFonso, Administrator, Division of Prevention and Education
Edward T. Duffy, Administrator, Division of Management and Budget
Felix R. Matlock, Administrator, Division of Field Services
Robert Stachura, Administrator, Division of Support Services
Krishan Kaistha, Ph.D., Chief Toxicologist

STATUTORY BODIES

Illinois Interagency Alcoholism and Substance Abuse Board

Lt. Gov. George H. Ryan, Chairman
Janet Otwell, Director, Illinois Department on Aging
Donald G. Gill, Illinois Superintendent of Education
Michael P. Lane, Director, Illinois Department of Corrections
James B. Zagel, Director, Illinois Department of Law Enforcement
Michael Belletire, Director, Illinois Department of Mental Health and Developmental Disabilities
Thomas B. Kirkpatrick, Jr., Director, Illinois Department of Public Health
Susan S. Suter, Acting Director, Illinois Department of Rehabilitation Services
Hon. Jim Edgar, Illinois Secretary of State
Harry R. Hanley, Acting Secretary, Illinois Department of Transportation
Gregory L. Coler, Director, Illinois Department of Public Aid
Gordon Johnson, Director, Illinois Department of Children and Family Services
Gary L. Clayton, Director, Illinois Department of Registration and Education

Illinois Advisory Council on Alcoholism and Substance Abuse

At this time, appointments to the Advisory Council have not yet been completed. The statutory membership is as follows:

—The President of the following organizations or his/her designee:
 Illinois State Medical Society
 Illinois Pharmacists Association
 Illinois Hospital Association
 Illinois Nurses Association
 Illinois Chapter, Association of Labor and Management Consultants on Alcoholism
 Illinois Alcoholism and Drug Dependence Association
—Executive Director, Illinois Commission on Children
—A local law enforcement official, appointed by the Governor
—A labor representative, appointed by the Governor
—An educator, appointed by the Governor
—A physician, appointed by the Governor
—A judge, appointed by the Chief Justice of the Illinois Supreme Court
—A state's attorney, appointed by the Illinois State's Attorneys Association
—A public defender, appointed by the Illinois Public Defenders' Association
—Four members of the Illinois Senate
—Four members of the Illinois House of Representatives
—Ten public members:
—Six appointed by the Governor, three of whom are representative of alcoholism and/or drug abuse rehabilitation programs
—One by each leader of the Illinois General Assembly

Department of Children and Family Services

160 North LaSalle Street, Room 1700, Chicago 60601
One North Old State Capitol Plaza, Springfield 62706
Gordon Johnson, Director

The Illinois Department of Children and Family Services is the state agency responsible for providing child welfare services and child protection services to children and their families. The current caseload is some 38,000 children and families. The Department's Division of Child Protection is responsible for investigating reports of suspected child abuse and neglect; in fiscal year 1984, some 66,846 children were reported as suspected abuse or neglect victims. The Department's Division of Youth and Community Services coordinates the provision of a number of special services for adolescents.

Services provided by the Department, either directly or through purchase from private agencies, include counseling/advocacy, homemakers, day care and child development, foster family home and other residential care, and parent education.

Director's Office

Paul Freedlund, Executive Deputy Director
John Robinson, Deputy Director for Program Operations
Thomas Villiger, Deputy Director for Child Protection
Bruce Rubenstein, Acting Deputy Director for Youth and Community Services
Mark Camille, Acting Deputy Director for Policy and Plans
David King, Deputy Director for Management and Budget
Donald H. Schlosser, Chief of Communication/Community Relations

Michael Prinzi, Chief Legal Counsel
William Hall, Legislative Liaison
Mauriece Graham, Chief of Internal Audits
James Stricker, Chief of Investigation
Robert Blackwell, Chief of Program Review
Michael Horstman, Special Assistant to the Director

Regional Offices

Thomas Brinton, Region 1A Administrator, Rockford
Thomas Ward, Region 1B Administrator, Peoria
Jack Zentz, Acting, Region 2A Administrator, Aurora
Roland Kulla, Region 2B Administrator, Cook County
William Gillespie, Region 3A Administrator, Springfield
Willis Hartman, Region 3B Administrator, Champaign
Anthony Jenkins, Region 4 Administrator, East St. Louis
Gene Ruehmkorff, Region 5 Administrator, Marion

Advisory Councils

DCFS Advisory Council, Edward J. Eagen, Chairperson
Statewide Citizen's Committee on Child Abuse and Neglect, Leatrice Kolber, Chairperson
Statewide Day Care Advisory Committee, Lana Hostetler Chairperson
Illinois Juvenile Justice Commission, Dallas C. Ingemunson, Chairperson

In addition to the above, each of the eight regions has its own advisory committee and youth planning committee.

Department of Corrections

160 N. LaSalle, Chicago, IL 60601 (312) 793-2955
1301 Concordia Court, Springfield, IL 62702 (217) 522-2666
Michael P. Lane, Director

Leo L. Meyer, Deputy Director-Adult Institutions
James R. Irving, Deputy Director-Juvenile Division
Douglas A. Brown, Deputy Director-Community Services
J. Thomas Hutchison, Deputy Director-Bureau of Administration and Planning
Dr. William H. Craine, Deputy Director-Bureau of Employee and Inmate Services
Robert H. Klemm, Deputy Director-Bureau of Inspections and Audits
Samuel J. Sublett, Accreditation Manager
Nic Howell, Public Information Officer
Dr. Ronald Shansky, Medical Director

Programs: 1) To develop and maintain reception and evaluation units for the purpose of analyzing the custody and rehabilitation needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, rehabilitation and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the State.

Department of Mental Health and Developmental Disabilities

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601
Michael A. Belletire, *Acting Director*
Paul Schyve, M.D., *Chief of Clinical Services*
Paul Schyve, M.D., *Associate Director for Mental Illness*
William K. Murphy, *Associate Director for Developmental Disabilities*
Terry Brelje, Ph.D., *Associate Director for Policy and Special Programs*
Ugo Formigoni, M.D., *Associate Director for Systems Development and Evaluation*

Office of the Director

Russell Blaauw, Legislative Liaison
Douglas Carey, Public Relations
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Gregory L. Coler, Director

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For information contact:
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Illinois Department of Public Health
525 W. Jefferson
Springfield, 62761
Phone: (217) 785-2080

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS
Illinois Department of Public Health
Division of Disease Control

For information contact:
Mary Mahoney—Coordinator, Direct Services Programs
Illinois Department of Public Health
Room 150, 535 West Jefferson Street, Springfield 62761
Phone (217) 782-3303

Department of Registration and Education

320 W. Washington Street, Springfield 62786
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The department is primarily concerned with the registration, licensing and enforcement of 31 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee, appointed by the director of the Department, operates within the framework of the act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, reviews alleged violations of the Medical Practice Act, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

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MEDICAL PRACTICE ACT

Due to its lengthy nature, IMJ is unable to publish the complete text of the Medical Practice Act. However, because of its importance to the practicing physician, physicians are encouraged to obtain a copy of the Act from the Department of Registration and Education, 320 W. Washington Street, Springfield, IL 62786.

Very briefly, changes were made during the past year to clarify insurance company obligations to report physicians who were involved in malpractice cases under the Act's mandatory reporting provisions. Another revision changed fees for medical licenses from $40 for a two-year license to $105 for a three-year license.

IMJ will continue to publish this annual summary of revisions to the Medical Practice Act as they are affected by the Illinois General Assembly and signed by the Governor.

Department of Rehabilitation Services

623 East Adams Street
Springfield, IL 62706
Susan S. Suter, Acting Director

The Department of Rehabilitation Services (DORS) is the state's lead agency helping disabled children, youth, and adults reach their full potential and their goals for a productive, independent life. Funded by state and federal funds, DORS provides a variety of rehabilitation services to eligible persons, including children and youth who cannot be adequately served by their local public schools; adults of or near working age who have diagnosable physical and/or mental disabilities which interfere with their ability to get or keep jobs; and severely disabled adults under age 60 who are at risk of institutionalization but who could remain at home if certain, specific services were provided.

DORS assists clients in selecting the needed services; serves as a link to service groups, rehabilitation facilities and other governmental agencies; and makes medical eligibility determinations for persons applying for benefits under the Social Security Disability Insurance and Supplemental Security Income programs.

DORS offers its services through a number of program components, including the Vocational Rehabilitation Program, the Home Services Program, the Illinois Visually Handicapped Institute, Community/Field Services for the Visually Handicapped, the Illinois School for the Deaf, the Illinois Children's School and Rehabilitation Center, the Illinois School for the Visually Impaired, the Secondary Work Experience Program and the Vending Stand Program.

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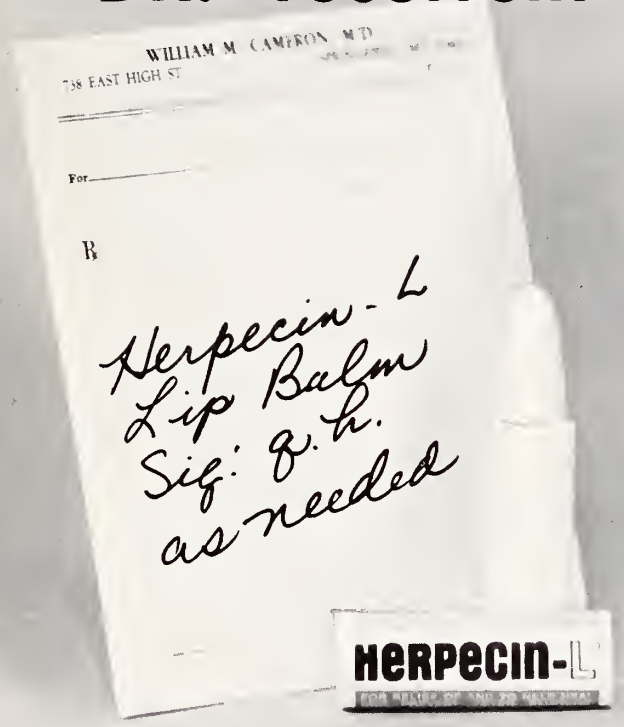
EKG

(Continued from page 208)

Answers: 1. E
2. A,E

The clinical syndrome of hypersensitive carotid sinus can result in hypotension and bradycardia with complaints of dizziness and even syncope. Most of the patients (some 70%) have cardioinhibitory problems resulting in sinus bradycardia, sinus arrest, and atrioventricular block. The remaining patients have vasodepressor syncope resulting in marked hypotension. These presyncopal or syncopal episodes can be precipitated by any factor that exerts pressure or tension on the carotid sinus. Some of these factors are: tight collars, pressure during shaving, sudden turning of the head, coughing, or straining at stool. The diagnosis is confirmed by applying manual pressure to the carotid artery. Light pressure is applied first. A definite response is considered three seconds or more of asystole or a decrease of 50mmHg or more in blood pressure. Carotid artery stenosis should be evaluated before carotid sinus massage. In our patient, right sided carotid sinus massage only caused some sinus bradycardia. The lead V_1, II, V_5 rhythm strip was recorded during left carotid sinus massage. The intraventricular conduction defect was complete left bundle branch block and the PR interval is 0.20 seconds. Carotid sinus massage caused sinoatrial block or sinus arrest for 3.4 seconds. This is followed by a junctional escape beat because the PR interval of this beat is probably too short to conduct to the ventricles. The sinus then appears at a rate of 80 beats per minute but no P wave conducts to the ventricles (*i.e.*, complete atrioventricular block). A permanent pacemaker is the appropriate treatment. Either digoxin or quinidine could worsen the problem. There was no evidence of metastatic disease in our patient. ◂

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Experience Leads Drs. Sohn, Hamilton to Run for Office

ISMS President Robert C. Hamilton, M.D., and Illinois Urological Society President Herb Sohn, M.D., both cited past experience as the major reason they are running for the University of Illinois Board of Trustees and the U.S. House of Representatives, respectively.

Dr. Sohn has actively campaigned for other congressional candidates. This was one of his prime motivations for running.

"The impetus that pushed me really is that I had helped a number of candidates run for office," Dr. Sohn said. "In the past three elections I helped John Porter, who is the representative in the 10th Congressional District. And looking at this individual who really has an excellent voting record, I realized that we needed more individuals of his caliber in government."

While Dr. Hamilton has not helped other individuals run for offices like a seat on the University of Illinois Board of Trustees, part of the reason he wants to serve his alma mater is his experience in serving DePaul University, where he is also a trustee.

"There are important decisions affecting the education of our young people made on the Board of Trustee level, and a physician's perspective is needed," Dr. Hamilton said. "That has been my experience at the Board level in organized medicine and how I became interested in serving the University of Illinois."

Dr. Hamilton is running as a Democrat and will be on the ballot statewide. Dr. Sohn is running as a Republican and is in the 9th Congressional District, which includes all of Evanston, and parts of Chicago, Skokie, Wilmette, Northbrook, Northfield, Golf and Morton Grove. ◀

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Physician Attitudes Toward Early Cancer Detection

By Penny L. Havlicek, M.A., Richard B. Warnecke, Ph.D. And Clara Manfredi, Ph.D./Chicago

This paper reports preliminary results of a medical care provider survey on attitudes and practices regarding early detection of cancer. In a previous study of Illinois residents, it was found that the relationship between physicians and patients had an important influence on whether patients obtained selected early cancer detection tests. In the study reported here, these same physicians were contacted in order to obtain information on their attitudes and practices regarding these tests. Preliminary results of the survey indicate that belief in the possibility of early detection and the performance and prescription of cancer early detection tests for most asymptomatic patients over 35 years of age varied significantly by cancer site.

This research was supported by the National Cancer Institute, Division of Cancer Control and Rehabilitation Grant No. N01 R18CA 21954.

The President's Committee on Education has defined health education as a process, "which bridges the gap between health information and health practices . . . [and] motivates the person to take the information and do something with it . . . [to] keep healthier by avoiding actions that are harmful and by forming habits that are beneficial."[1] Often, however, adequate education only partially determines behavior. Absence of support for (or presence of barriers to) health practices may circumvent education. This report examines physicians' attitudes toward early detection tests for cancer. These attitudes can either inhibit or facilitate the patients' obtaining these tests.

These issues were addressed in a Cancer Information Needs in Illinois study sponsored by the Illinois Cancer Council and conducted by the Survey Research Laboratory of the University of Illinois at Chicago. This project was to accomplish two goals. First, it was to determine and evaluate the most effective means of communicating information about prevention and early detection of cancer of specific sites (breast, cervix, uterus, prostate, colon, and rectum) to hard-to-reach rural and urban, low income population groups in Illinois. Second, it was to identify other factors that might inhibit behavior once proper information and motivation are present. To achieve these goals, a panel was surveyed about their knowledge, beliefs, and behavior concerning specific cancers before and after they received a specially designed communication on cancer. Various social psychological models of health behavior and communication, such as the health belief model[2] and the diffusion of innovation model,[3] were used to guide the preparation of the survey instrument and the special communication.

This study found two ways in which the physician affects receipt of early cancer detection tests. One concerned the quality of the patient-provider relationship. Patients who engaged in satisfactory dialogue with their physicians about health care were more likely to have regularly received early cancer detection tests.[4] In addition, among those who regularly received early detection tests, the physician rather than the patient tended to initiate the test. Because the health care providers played such an integral part in the health behavior process, their attitudes and beliefs toward cancer prevention and early detection must be determined and considered in conjunction with patient characteristics in order to fully understand the process.

The purpose of this report is to present preliminary results of a sur-

Table 1
Description of the Physician Sample

Disposition	Number
Total number of physicians	1,281
Ineligible sample	
Deceased, retired	95
Unable to locate	104
Pretest cases	47
Ineligible due to specialty	102
Total ineligible	348
Eligible sample	
Completed full interviews	681
Completed short interviews	201
Refusals, noncontacts, unavailable	51
Total eligible	933

Table 2
Percentage of Physicians Reporting Selected Types of Practices

Type of Practice	%*
Hospital-based intern or resident	0.2
Hospital-based full-time staff	28.3
Hospital-based part-time staff	4.4
Office-based private solo practice	53.0
Office-based private group practice	34.8
Office-based prepaid group practice or HMO	1.5
Office-based public clinic	1.5
Other	2.0
	N = 909

**Percentages da not add to 100 because physicians could indicate more than ane type of practice.*

vey of physician attitudes and beliefs about cancer prevention and detection. Respondents to the Cancer Information Needs in Illinois study provided names and addresses of their physicians so that reports of early cancer detection tests could be verified. This study presented an exceptional opportunity to study this problem because the respondents' providers constituted a convenient and general sample of Illinois physicians.

Methods and Sample

The survey contained questions on four major topics: (1) belief in early detection of cancer, (2) performance or prescription of early detection tests, (3) performance or prescription of periodic medical checkups, and (4) the nature of the physician's medical practice. Originally intended for all the physicians reported by respondents in the Cancer Information Needs in Illinois study and pretested on a small subsample of these physicians, the survey was later limited to those physicians most likely to provide or prescribe early detection tests. Physicians were considered eligible for the study if they (1) were family or general practitioners; (2) were specialists in allergy, cardiology, gastroenterology, internal medicine, urology, obstetrics/gynecology, ear, nose, and throat, endocrinology, hematology, obesity, oncology, pulmonary lung disease, general preventive medicine, proctology, occupational medicine, rheumatology, or diabetes; or (3) provided a complete periodic medical checkup to asymptomatic patients.

Eligible physicians were identified from among those physicians in our sample by a series of screening questions which could be answered by either the physicians themselves or their office staff. Only when it was determined that the physician in fact met one of the criteria was he sent a questionnaire accompanied by an introductory letter as well as a letter from the Illinois State Medical Society endorsing the study to encourage responses. The study design provided for two mail follow-ups if no response to the initial questionnaire was obtained. If no response to the follow-up questionnaires was obtained, an attempt was made to get the information via the telephone.

Table 1 describes the final dispositions of the physician sample. The initial sample of 1,281 physicians was the number of unique physicians reported by all respondents over all waves of the Cancer Information Needs in Illinois panel as a source of one of more specified cancer early detection tests. Of these 1,281 physicians, 933 were determined to be eligible for this study. The final sample of 681 completed, full interviews represents a "response rate"[5] or a "final completion rate"[6] of 73.0% (number in final sample divided by number in eligible sample). This rate falls well within the 41% to 80% Shosteck and Fairweather[6] observed for mail surveys to physicians and the 65% to 80% they observed for face-to-face interviews with physicians. For questions contained in the screener, the final sample size is 984, which includes the eligible physicians who completed full interviews (681), the eligible physicians who only completed the screener or short interview (201), and the specialists who completed the screener but were found to be ineligible (102).

Findings

The data presented address three topics: (1) the types of medical practices included in the sample, (2) the physicians' attitudes and behavior concerning periodic medical checkups, and (3) the physicians' attitudes and behavior concerning early detection of cancer. Information about the medical practices was obtained from all screener respondents regardless of their eligibility and provides a context for data on attitudes. The data presented on the last two topics are based on the completed eligible sample. Because of missing information, the actual number of cases on which the statistics presented are based frequently differ from the final sample sizes mentioned above. The actual number of cases are presented in the text where appropriate or are clearly indicated in the tables.

Table 3
Most Frequently Reported Specialties*

Specialty	% Reporting
Internal medicine	28.4
Obstetrics and gynecology	16.4
General surgery	12.0
Family practice	12.0
Surgery	5.4
Urology	4.5
Cardiology	3.2
General practice	1.9
Orthopedic surgery	1.5
Gastroenterology	1.1
Other	13.6
	Total 100
	N = 719

**Only those specialties reported by more than 1% of the specialists are listed. Specialties reported by 1% or less of the specialists are included in the other category. Forty-two different specialties were mentioned.*

Table 4
Percentage of Physicians Reporting That Selected Examinations Are Always Included as Part of a Complete Medical Checkup

Examination	%
Palpation of head and neck	97.2
Palpation of abdomen	99.3
Stethoscope auscultation	97.0
Visual examination of eyes, nose, throat	93.2
Blood pressure measurement	99.0
Urinalysis	91.8
Routine blood tests	77.7
	N = 574

Medical Practice

Physicians were asked to describe their current clinical practices. Table 2 reports their responses. By far, the most common type of practice was private and office-based, followed by full time hospital based practice. The percentages of physicians reporting other practice situations were negligible.

The sizes of the physicians' practices varied considerably. The average number of patients per week ranged from five to 700 among the 826 physicians who answered this question, although approximately 80% of the physicians reported between 45 and 210 patients per week on the average. The median average number of patients was 110. Similarly, the average number of patient visits per week reported by the American Medical Association for all specialties in 1980 was 112.[7] Nearly three quarters of the physicians (N = 806) estimated that less than 10% of their patients were cancer patients.

About 40% of the physicians (N = 901) graduated from schools in Illinois. The University of Illinois was by far most frequently mentioned. About 25% of the physicians graduated from foreign medical schools.

Seventy-five percent of the physicians (N = 971) were specialists. In contrast, according to figures published by the American Medical Association for a comparable year, 84% of the nonfederal physicians in Illinois whose major professional activity is patient care are specialists.[8] Our sample included federal physicians, but federal physicians also tend to be specialists.[8] Thus, it seems our sample contained a disproportionate number of nonspecialist general or family practitioners.

The most frequently mentioned specialities in our sample, however, correspond well to the most frequently reported specialities in the American Medical Association sample. The most frequently mentioned specialties in our sample are reported in descending order in Table 3. The three most frequently mentioned specialties among nonfederal physicians engaged in patient care in the American Medical Association's sample of Illinois physicians are, in descending order, internal medicine, general surgery, and obstetrics and gynecology. In some respects, then, the physicians in our sample seem fairly representative of Illinois physicians, even though they served a special population.

Medical Checkups

Checkups are important for the early detection of cancer because they may provide the context in which early detection tests are given.[9] Physicians were asked a series of questions about periodic medical checkups. Most physicians felt that complete periodic medical checkups were important for asymptomatic patients over 35 years of age. Of the 665 physicians who answered this question, only 13% felt such checkups were unimportant.

Seventy-eight percent of the physicians who completed the screener (N = 972) reported that they routinely provided complete periodic medical checkups. Table 4 shows the extent to which our sample included selected examinations in the periodic medical checkups. There is little variation in percentage of physicians who reported providing each of these tests, and the percentages are consistently very high. Four tests were provided as part of a complete medical checkup by nearly 100% of our physicians: palpation of the head and neck, palpation of the abdomen, stethoscope auscultation, and blood pressure measurement.

Some physicians indeed reported that they included certain early cancer detection tests as part of a complete periodic medical checkup. Sixty-seven percent and 57% of physicians (N = 574) reported including a rectal examination and pelvic examination, respectively (data not presented). The Pap smear was included by 44% of the physicians, and breast palpation by 25%. Mammography, prostate examination, and proctoscopy were

Table 5
Percentage of Physicians Reporting That Detection of Cancers in Their Earliest Stages Was Possible for Selected Cancer Sites

Cancer Site	% Yes	N
Cervix uteri	99.2	662
Uterus	78.7	657
Breast	83.6	658
Colon	69.9	652
Rectum	87.0	654
Prostate	63.8	649
Bladder	57.2	652
Skin, besides melanoma	95.7	649
Oral cavity	89.7	650
Larynx	63.2	647
Lung	41.1	652

Table 6
Percentage of Physicians Reporting That Early Detection of Cancer Was of Great Benefit for Selected Cancer Sites

Cancer Site	% Yes	N*
Cervix uteri	97.8	642
Uterus	87.0	500
Breast	82.6	536
Colon	79.5	443
Rectum	81.9	552
Prostate	69.1	408
Bladder	69.0	364
Skin, besides melanoma	84.0	589
Oral cavity	76.7	557
Larynx	72.6	391
Lung	63.2	261

**The N is composed of those individuals who thought early detection was possible.*

Table 7
Percentage of Physicians Reporting That They Perform or Prescribe Selected Early Detection of Cancer Tests for Most Asymptomatic Patients Over 35

Cancer Detection Test	%	N
Pap smear	95.8	669
Clinical Breast Exam	97.0	670
Mammography	4.3	648
Manual Rectal Exam	90.1	670
Proctoscopic Exam	18.9	646
Prostatic Exam	80.9	634
Pelvic Exam	93.7	667
Chest X-ray	39.2	653
Oral Exam	86.8	651

included as part of a checkup by fewer than 10% of the physicians.

Early Cancer Detection Tests

The physicians who completed the questionnaire were asked whether detection of cancer in its earliest stages was in fact possible for selected cancers. Table 5 summarizes the responses to this question. The percentage of physicians who reported that early detection was possible varied considerably by cancer site. Nearly all physicians agreed that early detection of cancer of the cervix uteri was possible. On the other hand, only 41% of the physicians thought lung cancer could be detected early.

Those physicians who thought early detection was possible were asked whether it was of great benefit. There was considerable variation by cancer site in the percentage of physicians who thought early detection was beneficial (Table 6). Optimism about the benefit of early detection and belief in detectability were correlated. The ranking of cancers by detectability (Table 5) was correlated with their ranking by benefit of early detection (Table 6) by calculating the statistic rho. This statistic is calculated by formula:

$$\text{rho} = 1 - 6\epsilon D^2/N(N^2 - 1)$$

where D is the discrepancy between paired ranks and N is the number of items ranked.[10] The resulting coefficient tells us how well we can predict one set of ranks from another; a coefficient of one indicates perfect predictability, and a coefficient of 0 indicates no predictability. The correlation between ranks of cancer sites in Tables 2 and 3 yielded an rho of .827, which indicates fairly good predictability between ranks.

Finally, the extent to which physicians perform or prescribe early detection tests for most asymptomatic patients over 35 years of age was determined. Table 7 reveals substantial differences in the extent to which various tests were performed or prescribed. Nearly all physicians reported that they performed or prescribed the Pap smear and the clinical breast exam, while only 4% perform or prescribe mammography. The reason most frequently given for not performing or prescribing mammography,

proctoscopy, and a chest X-ray for most asymptomatic patients over 35 years of age was that low positive returns were not worth the trouble for general screening.

An important question is to what extent do belief in the possibility of early detection of a cancer and belief in the benefit of early detection of that cancer determine the performance or prescription of an early detection test for that cancer. We can examine this problem superficially by comparing the percentages of physicians with these two beliefs with the percentages of physicians who perform or prescribe the early detection tests listed in Table 7. For example, belief in the early detectability of cancer of the uterus cervix (Table 5) and belief in the benefits of early detection of this cancer (Table 6) are quite prevalent. Logically enough, performance or prescription of the Pap smear is also quite prevalent. On the other hand, while belief in early detectability of colon cancer is moderately prevalent (69.9%) and belief in the benefits of early detection of colon cancer is prevalent (79.5%), the performance or prescription of the proctoscopic exam is quite low (18.9%). This comparison implies that beliefs may predict the performance or prescription of some tests but not the performance or prescription of others.

Apart from beliefs about early detection, a number of other reasons come to mind as to why an exam may or may not be performed. We have already mentioned that a reason why proctoscopy and other exams are not performed or prescribed is the low positive returns associated with them. Other possible reasons are cost to the patient, ease of application, and perhaps effectiveness of the exam. Further analysis must be done in order to fully separate these factors and their impact on the performance or prescription of these tests.

Summary and Conclusions

A sample of Illinois physicians of various specialties and practices expressed a range of opinions about medical checkups and early cancer detection tests. While most physicians thought periodic medical examinations for asymptomatic patients over 35 were important, there was some variation in the types of examinations included as part of a checkup. Nearly all physicians thought that certain cancers could be detected early, but they differed considerably on detectability of other cancers. Similarly, nearly all the physicians reported performing or prescribing some of the tests for early detection, while relatively small percentages of physicians performed or prescribed other tests.

These findings show that there is indeed a rich diversity of opinion about cancer prevention and detection within the medical profession. Such findings imply that physicians' influence on whether patients obtain early cancer detection tests is not uniform but constitutes an important variable. This variable must be taken into account in any model explaining the health behavior of the individual. ◀

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MSS in Action

(Continued from page 193)

itor the ongoing AMA study, "1984 Initiatives in Health Care for the Elderly," and report findings at the December meeting.

At almost every meeting there are resolutions submitted by students requesting that the AMA encourage medical schools to include in their curricula courses such as computers in medicine, medical ethics, economics, law, and so on. Illinois students have asked the MSS to consider forming a task force on medical education to advise students on how to best promote these ideas.

Election Results

Resolutions to the AMA were not the only important business at the A-84 meeting. A new MSS governing council was elected. They are: David Brailer (West Virginia U), chair; Michael Laufer (Stanford), vice-chair; Leon Dent (Morehouse), delegate to the AMA; Gail Williamson (U of Illinois), alternate delegate; and Grant Mitchell (NY Medical College), at-large officer. It is a particular honor to be elected to the MSS governing council, and, as the alternate delegate to the AMA House, Gail will have the opportunity to present the ideas and positions of Illinois students directly to the most influential body in American medicine.

Ron Davis, M.D., a graduate of the University of Chicago and a past chairman of the AMA-MSS, was elected to fill the newly created resident seat on the AMA Board of Trustees. Alice Chenault, a student from the University of Alabama chosen by the MSS assembly at the last interim meeting, was approved by the AMA Board for its new student seat. As holders of these new positions, the resident and student trustees will be able to participate in developing and implementing health policy which is in the best interest of the American public and the medical profession. Both Dr. Davis and Ms. Chenault started out as MSS delegates from their schools, became active participants at the MSS annual meetings, and eventually assumed positions of national leadership.

The Illinois student delegates, alternates, and the MSS as a whole have lived up to their purposes of presenting student concerns and providing a social conscience to the AMA. Any student with an idea for improving the health status of the population, or health care delivery, can work with his or her MSS school representative to develop their concept into a resolution, which if adopted by the national MSS assembly, will be forwarded to the AMA. Students are also welcome to come and participate directly at monthly ISMS-MSS meetings, which are held at ISMS headquarters, Twenty North Michigan Avenue, Suite 700. At our next meeting (November 26 at 6 pm), we will be preparing our agenda for the national meeting to be held in December.

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2 yrs.		25.95
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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Complications have been reported in 4.22% of 995 patients undergoing coronary angiography within a one year period. Dr. Harris performed a bivariate analysis from five U.S. Army tertiary care medical centers and concluded that gender, the brachial technique, arterial in-time, and the hospital in which the procedure was performed were statistical risk factors. The risk of complications was not related to physician training level, patient age, hypertensive history, anginal frequency, congestive heart failure, prior MI left main coronary disease, ejection fraction, or left ventricular end-diastolic pressure. Complications occurred in 16.1% of women studied by the brachial approach and in 3.8% when the femoral approach was used. (Harris, J.M., *Arch Int Med* 144:337-41, Feb. 1984)

Dr. Sherman, *et al,* report that 2-5% of the general population over 60 years of age have experienced atrial fibrillation and more than a third exhibit autopsy evidence of arterial emboli. A retrospective study of 150 cases with atrial fibrillation showed an incidence of cerebral or peripheral embolism in 31%. No cardiac valvular disease was noted in 80% of cases and most did not exhibit transient cerebral ischemic attacks. Approximately 10% of stroke patients have atrial fibrillations and these cases tend to manifest multiple embolic events. (Sherman, D.J., *et al: Arch Neurol* 41:708-10, July 1984)

Cardiac ergometric studies were performed in 18 normal and 20 diabetic cases with gated radionuclide angiography. These cases were 21-44 years of age and without clinical evidence of heart disease. Both groups had a similar rest and exercise heart rate and blood pressure, and both groups achieved similar work loads. In seven of the 20 diabetic cases the exercise test showed a decrease in the ejection fraction. Others showed other variations with an increase to 25% and a decrease to 21%. The authors concluded that one third of these asymptomatic diabetic patients had subclinical left ventricular dysfunction. Whether this was due to coronary artery disease or primary myocardial disease was not known. (Mildenberger, R.R., *et al: J Am Col Card.* 4#2:234-8, Aug. 1984)

Nasal air was oscillated at 8Hz, 14Hz and 20Hz by a loudspeaker attached to a nasal mask. Mucociliary transport was evaluated by the saccharin clearance time. Mucociliary transport was increased at all frequencies with an overall mean rise of 161%. These waves have a zero mean pressure and flow and thus may be useful to improve viscoelasticity or ciliary function in patients with overproduction or retention of mucus within the nasal passages or intrathoracic airways. (George, R.J., *et al: Lancet* #8393:10-2, July 7, 1984)

Electrocardiography is generally performed in the supine position. The authors of a recent article suggest that a tilt table be used for electrocardiography in patients with suspected rhythm disturbances. The upright position displaces the blood. It elicits vasoconstriction to maintain arterial pressure and a concomitant increase in the catecholamine that may aggravate tachyarrhythmias. If the vasoconstrictor response is absent a vasodepressor, syncope may be precipitated. In 104 patients between 37-81 years of age with diagnoses of supraventricular tachycardia, vasovagal syncope and carotid sinus hypersensitivity, an abnormal EKG in the upright was noted in 22% of the cases that was not present in the supine position. (Hammill, S.C., *et al: J Am Col Card* 4#1:65-71, July 1984)

Between the years 1979-1982, toothpicks accounted for 3.6 injuries per 100,000 population per year. Injury was more common in children between 5-14 years of age, but those younger than five had a rate of injury to the eye and ear more than 20 times greater than that of other persons. Gastrointestinal involvements have been reported, less frequent findings as sepsis, cardiovascular, pleural and soft-tissue complications have also been described. The authors conclude that since young children appear to be at greatest risk, toothpicks should be kept out of their reach. (Budnick, L.D.: *JAMA* 252#6:796-7, Aug. 10, 1984)

The authors discuss two cases of septic shock with prolonged hypotension that did not respond to conventional intensive care, dopamine, intravenous fluids, diuretics and steroids. They then used intravenous naloxone with remarkable beneficial effect. They conclude that endorphins released by stress may play a role in acute hypotension. The mortality in septic shock has been reported as between 40-70% despite antibiotics and intensive supportive care and thus may warrant investigation of the use of intravenous naloxone. (Siram, S., Park, S.: J Nat. Med. Assoc. 76#7:713-6, July 1984)

The Center for Disease Control has revised its recommendations for the prevention and treatment of influenza. They report that most deaths occur in high risk patients over 65 years of age and those with chronic diseases. In addition to adults and children with chronic disorders of the cardiovascular and pulmonary systems, medical personnel who may spread the disease should be considered for prophylactic inactivated influenza vaccinations. Two annual vaccinations with split virus up to 12 years of age are suggested four weeks apart. Over 12 years of age the whole or split vaccine may be given in single doses annually. Pneumococcal vaccine may also be given simultaneously at a different site but only once during the patient's lifetime. The antiviral agent amantidine hydrochloride is the only specific prophylactic and therapeutic medication effective in 70-90% of cases. (Immunization Practices Adv. Com.: *Ann Int Med* 101#2:218-22 Aug. 1984)

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

NOVEMBER

Internal Medicine

Advances in Internal Medicine
For: Internists. Lecture, November 12-16, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $500.00. **Reg. Limit:** 20. **Credit:** Category 1, 35 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Fiberoptic Esophagogastric Endoscopy
For: MDs. Lecture, November 12-14, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $490.00. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Flexible Fiberoptic Sigmoidoscopy
For: MDs. Lecture, November 17, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $145.00. **Reg. Limit:** 75. **Credit:** Category 1, 7 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Cardiology

Current Cardiology: Adults
For: MDs. Lecture, November 5-8, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee** $395.00. **Reg. Limit:** 90. **Credit:** TBA. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

2nd Annual L.R. Nelson Cardiovascular Conference
For: MDs, RNs, Techs. Conference, November 3, 9:30am-2:30pm, Peoria, Illinois. **Sponsor:** Methodist Medical Center of Illinois and The Methodist Medical Center Foundation, 221 NE Glen Oak, Peoria, IL 61636. **Fee** $15.00. **Reg. Limit:** 100. **Credit:** Category 1, 5 hours. **Contact:** Irving Favis, MD. **Phone:** 309-672-5737

Current Cardiology: Children
For: MDs. Lecture, November 9-10, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, Illinois 60612. **Fee** $340.00. **Reg. Limit:** 90. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Cardiac Rehabilitation Workshop
For: MDs, RNs, PTs. Workshop, November 12-16, LaCrosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program Education Services Unit, Mitchell Hall, University of Wisconsin-LaCrosse, LaCrosse, Wisconsin 54601. **Fee** $450.00. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN=3.5 CEUs; Wisconsin Nurses Association, 35 hours; Iowa and Kansas PTs, 35 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** 608-785-8686

Infection Control

Advances in Control of Nosocomial Infection
For: MDs. Conference, November 15-16, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AAFP Prescribed, TBA; AOA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Geriatrics

Aging and Illness in Primary Care—4th Symposium On Ethical and Clinical Problems in the Care of the Elderly
For: MDs. Symposium, November 8-9, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee** TBA. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; University of WI-Extension CEU, 13 hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Genetic Diseases

Genetic Determined Diseases
For: MDs. Symposium, November 10, 8am-12:30pm, Decatur, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

Medicine & Pathology

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, November 26, 4:30pm-6:30pm, North Chicago, Illinois. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, Illinois 60064. **Fee** None. **Reg. Limit:** None. **Credit:** AMA Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Instrumentation in Clinical Microbiology
For: Pathologists, Microbiologists. Lecture, November 12 at 7:00 pm, Chicago, IL. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall H. Short, MD. **Phone:** 312-626-4300

Surgery

Facial Trauma Conference
For: MDs. Symposium, November 9, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, IL 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711

Obstetrics and Gynecology

Infections in Obstetrics and Gynecology
For: MDs. Symposium, November 30-December 1, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, IL 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711

Intensive Care

Trauma Conference
For: MDs. Conference, November 30, 8am-5pm, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, CME, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBD. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Allergy

Clinical Allergy for the Practicing Physician
For: MDs. Seminar, November 8-10, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid St., St. Louis, MO 63110. **Fee:** $250.00. **Reg. Limit:** 150. **Credit:** AAFP Prescribed, 19 hours; AMA Category 1, 19 hours, AOA, 18.5 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862

IgE and New Aspect of Hyper IgE Syndrome
For: Allergists. Lecture, November 19, 7:00 pm, Holiday Inn, Chicago, Illinois. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Highway, Mount Prospect, Illinois 60056. **Fee:** $15.00. **Reg. Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312-255-1024

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For further information about participating in a unique ICCME seminar, please contact the Illinois State Medical Society, Twenty North Michigan Avenue, Chicago Illinois 60602 (312-782-1654).

Stress Management

Anxiety and Depression

For: MDs. Symposium, November 29, 2:30 pm—7:45 pm, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee:** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Charles E. Osborne, Ed. D. **Phone:** 217-782-7711

Teaching Stress Management and Relaxation Skills

For: MDs, RNs, PTs, OTs. Workshop, November 11-15, LaCrosse, Wisconsin. **Sponsor:** LaCrosse Exercise Program Education Services Unit, University of Wisconsin-LaCrosse, Mitchell Hall, Room 221, LaCrosse, WI 54601. **Fee:** $450.00. **Reg. Limit:** 40. **Credit:** Category 1, 35 hours; AAFP Prescribed, 35 hours; AACN, 3.5 CEU; Nurses Assn., 35 hours; Iowa and Kansas, PT, 35 hours. **Contact:** Philip K. Wilson, Ed.D. **Phone:** 608-785-8686

DECEMBER

Internal Medicine

Management of Difficult Arrhythmias

For: MDs. Symposium, December 7, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, IL 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711

Advanced Trauma Life Support Providers Course

For: MDs. Workshop, December 13-14, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, IL 62708. **Fee:** TBD. **Reg. Limit:** 16. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711

Lake County Liver and GI Clinico-Pathological Conferences

For: MDs. Lecture, December 17, 4:30-6:30PM, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** None. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Gynecology

Problem Solving in Gynecologic Endocrinology and Infertility

For: MDs. Course, December 7-8, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $250.00. **Reg. Limit:** None. **Credit:** Category 1, 10 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Neurology

The Second Comprehensive Neuroimmunology Conference

For: Neurologists. Course, December 5-8, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $300.00. **Reg. Limit:** None. **Credit:** Category 1, 24 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Neurology for the Non-Neurologist

For: MDs. Course Review, December 12-14, The Westin Hotel, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, University Office of Continuing Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** $350.00. **Reg. Limit:** None. **Credit:** AAFP Elective, 20 hrs. **Contact:** Barbara Trejo. **Phone:** 312-942-7119

Pediatrics

Current Problems in Pediatrics

For: MDs. Lecture, December 3-7, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, IL 60612. **Fee:** $540.00. **Reg. Limit:** 90. **Credit:** Category 1, 40 hrs., Other: PREP. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Sports Medicine

2nd Annual Hawkeye Sports Medicine Symposium

For: MDs, RNs, PTs, PAs. Symposium, December 6-8, 8-5pm, Iowa City, Iowa. **Sponsor:** The University of Iowa College of Medicine, 285 ML, Iowa City, IA 52242. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBA. **Contact:** Deborah L. Hatz. **Phone:** 319-353-5763

Cardiology

New Approaches to Management of Profound Congestive Heart Failure. The 4th Annual Conference on Heart Diseases

For: MDs. Lectures, Workshops, December 7-8, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, 10 hrs. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Pathology

A Pathologist View: 1) Relationship Between Gastro-Esophageal Reflux, Bronchial Asthma and Barrett's Epithelium; and 2) Histochemical and Immunocytochemical Aspects of Gastric Dysplasias and Neoplasias

For: Pathologists. Lecture, December 10, 7:00 pm., Drake Hotel, Chicago, IL. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central Ave., Chicago, Illinois 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312-626-4300

JANUARY

Surgery

Specialty Review in Thoracic Surgery

For: MDs. Lecture, January 7-12, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $600.00. **Reg. Limit:** TBA. **Credit:** Category 1, 46 hours. **Contact:** Robert J. Baker, MD. **Phone:** 800-621-4649

Specialty Review in General Surgery, Part II

For: MDs. Lecture, January 29-February 8, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $750.00. **Reg. Limit:** TBA. **Credit:** Category 1, 100 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 800-621-4649

Cardiology

Modern Cardiology and Technology

For: Cardiologists, MDs. Lecture, January 16, 23 and 30, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $100.00 **Reg. Limit:** 90. **Credit:** Category 1, TBA. **Contact:** Robert J. Baker, MD. **Phone:** 800-621-4649

Nutrition

A.S.P.E.N.'s Annual 9th Clinical Congress

For: MDs. 9th Clinical Congress, January 21-24, Miami Beach, Florida. **Sponsor:** The American Society of Parenteral and Enteral Nutrition, 1025 Vermont Ave, N.W. Washington, D.C. 20005. **Fee:** $120-250. **Reg. Limit:** None. **Credit:** Category 1, 25 hours. **Contact:** Donna M. Baudrau. **Phone:** 202-638-5881

Allergy

Impact on Health Maintenance Organizations on Allergy Practice-Present and Future

For: Allergists. Lecture, January 21, 8:00 pm, Holiday Inn, Chicago. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Highway, Mount Prospect, Illinois 60056. **Fee:** $15.00. **Reg. Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312-255-1024

Radiology

Update in Radiology

For: MDs. Symposium, January 10, 1:00-5:00 pm, Lincoln, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee:** $45.00 **Reg. Limit:** None. **Credit:** Category 1, 4 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

General Medicine

Medical Seminar-at-Sea

For: MDs. Seminar, January 19-30, Caribbean Cruise. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee:** $500.00 **Reg. Limit:** None. **Credit:** Category 1, 48 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

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*Additional diagnostic information on page 210

CLASSIFIED ADVERTISING

SPECIAL NOTE FOR READERS RESPONDING TO BOX NUMBERS: At press time, the ISMS office move was scheduled for October 23. Persons responding to a box number prior to that date should address correspondence to 55 E. Monroe. Persons responding after that date should write to the PO Box number c/o IMJ, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

Classified Advertising Rates

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
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FAMILY PRACTITIONER/INTERNAL MEDICINE—To locate in Rosiclare, Illinois. 49-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. Contact Roby Williams, Administrator, P.O. Box 467, Rosiclare, IL 62982. (618) 285-6634.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialties in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full and part time opportunities for well qualified emergency physicians in a northwest Chicago suburb. Excellent compensation package. Respond with C.V. to: Debbie Hibberts, EMSA, 8200 W. Sunrise Blvd, Bldg. C, Plantation, FL 33322 or call collect (305) 472-6922.

MEDICAL DIRECTOR for Correctional Center Hospital Unit. Correctional Medicine experience preferred. Prefer internal medicine or family practice training. Income in excess of $100,000 per annum. Part-time staff physicians also needed. Send CV in confidence to Mr. Tim Ryan, 179 W. Washington, Suite 1100, Chicago, IL 60602, or call 312-372-1539.

PHYSICIAN OPPORTUNITIES: Current openings for family practitioners, internists, general surgeons, industrial physician. Chicago suburb, south. Reply to Box #1122, c/o the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago IL 60603.

EMERGENCY DEPARTMENT ASSOCIATE DIRECTOR—Illinois progressive facility with strong community orientation in Western Illinois seeks board certified/eligible FP, IM, GS or EM Specialist. Position offers excellent remuneration and comprehensive malpractice insurance. Reply to: Amy Eisenman, Staffing Specialist. National Emergency Services, Inc. 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

MISSOURI AND ILLINOIS—Emergency Medicine. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Amy Eisenman, Staffing Specialist. National Emergency Services, Inc, 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

MEDICAL DIRECTOR. Opportunity for physician with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; phone 608-251-4156.

FAMILY PRACTICE. Rapidly expanding staff model HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; 608-251-4156.

OB/GYN. Group Health Cooperative has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; phone 608-251-4156.

OBSTETRICIAN-GYNECOLOGIST needed for prosperous community of 12,000 which is 1½ hours from the Chicago Loop in central Illinois. Minimum guarantee $150,000. Please submit CV to Bromley and Associates, 1010 Jorie Blvd., Suite 234, Oak Brook, IL 60521, or phone 312-986-5870.

CHICAGO: Experienced Family Practitioner wanted for Hospital Affiliated Clinics in southwest suburban areas. Regular hours, no night call. Minimum guarantee $90,000 with fee-for-service. Call or send CV to: Dr. Horton, 179 W. Washington, Suite 1100, Chicago, IL 60602, or call (312) 372-1539.

FAMILY PRACTITIONER—Available immediately, new extended hours F.P. center needs full time physician. Excellent opportunity for right F.P. Growing community with resort facilities, servicing two hospitals. C.V. or call—Dr. Stewart Segal, 740 Chaucer Way, Buffalo Grove, Ill. 60090; 312-634-6547.

INTERNIST/BOARD ELIGIBLE or certified with subspecialty in infectious diseases wanted to join the busy, suburban practice of a solo internist. Excellent potential for rapid growth. Send curriculum vitae to Box #1128, c/o the Illinois Medical Journal, 55 E. Monroe, Suite #3510, Chicago, IL 60603.

BOARD CERTIFIED, 35-ish, male family physician with rapidly growing practice in Baltimore-Washington area seeks associate inter-

ested in and familiar with women's medical needs. POB 684 Columbia, MD 21045.

INTERNIST—Looking for added income opportunity with no financial investment? Board Certified Internists required for disability examinations in downstate Illinois locations. Reply to Box 1135, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

INTERNIST: B/C-B/E to join well established group immediately, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

FAMILY PRACTITIONER: B/C-B/E to join well established group immediately, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

BE OR BC INTERNIST with subspecialty in Infectious Diseases needed to join busy solo internist practicing in suburban Chicago area. Very good potential for rapid growth. Send CV to Box 1134, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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CARDIOLOGIST: Opportunity to practice cardiology with well-established practice conveniently located to a large teaching hospital. Duties include supervising and interpreting Treadmills, Holter monitors, 2D and M-Mode Echocardiography performed in office, patient examinations, hospital rounds and cardiac catheterizations. Abilities to do streptokinase and/or angioplasty desirable. Excellent beginning salary and fringe benefits. Located in Pennsylvania. Immediate Opening. Reply with C-V to Box #1132, c/o the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

GENERAL/FAMILY PRACTICE Southern California CIGNA Healthplans of California has over 28 facilities in Los Angeles and Orange County and more than 350,000 members. Our 370 full-time physicians enjoy a personal patient population and continuity of care. Significant growth has created opportunities for experienced specialists and General and Family Practitioners to join our professional team and share in our excellent compensation and benefits package. For more information send curriculum vitae to Director/Physician Recruitment: CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500, Glendale, CA 91203.

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POSITION AVAILABLE Assistant Professor of Obstetrics and Gynecology at Rush Medical College and Supervisor of In Vitro Fertilization (IVF) laboratory. Duties include academic instruction, research and supervision of the IVF laboratory. Applicants must have a Ph.D. in Physiology or Biology and 1-2 years University level teaching experience. Knowledge of human IVF techniques and laboratory management are essential. Salary commensurate with experience. Submit curriculum vitae and cover letter to W. Paul Dmowski, M.D., Ph.D., Director, Section of Reproductive Endocrinology and Infertility, Rush Medical College, 600 So. Paulina Street, Chicago, Illinois 60612. Equal Employment Opportunity/Affirmative Action Employer.

SITUATIONS WANTED

POSITION WANTED—RADIOLOGIST seeking position full time, part time or locum tenens. Trained in diagnostic modalities. Write to Box #1096 c/o *Illinois Medical Journal*, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

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PEDIATRICIAN, seeking position full-time or part-time to join an obstetrician or a group of physicians. Available July 1, 1984. Write or call: Dr. Sandesara, 5906 North Sheridan Road, #4A, Chicago, Illinois 60660; (312) 769-4384 (after 6:00 p.m.).

GOOD GENERAL OR INTERNAL MEDICINE practice wanted in Chicago or southwest suburb. Reply to Box #1133, c/o the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

GASTROENTEROLOGIST, 34, Board Certified, U.S. graduate with 3 years of clinical experience seeks practice opportunities in Northern Illinois. Reply Box #1138, c/o *Illinois Medical Journal*, 55 E. Monroe, Suite #3510, Chicago, IL 60603.

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The Physician Volunteer



Volunteers play an extremely important and critical role in our Society. They do so in many varied ways. Some do so through membership on ISMS councils and committees. Others testify in public hearings and study documents submitted for public comment. Some contribute indirectly, supporting the fine work of their spouses through another very important volunteer activity, the ISMS Auxiliary. Many more have volunteered as ISMS Key Contacts for the Society's legislative program.

This month, I'd like to call attention to one member whose work for the Society has been outstanding and unique.

John M. Beal, M.D., edited the *IMJ* "Surgical Grand Rounds" column for 17 years, from 1966 until his retirement this Spring. During this time, he was in active practice as well as Chairman of the Department of Surgery at Northwestern Memorial Hospital and a Professor and Chairman of the Department of Surgery at Northwestern University Medical School.

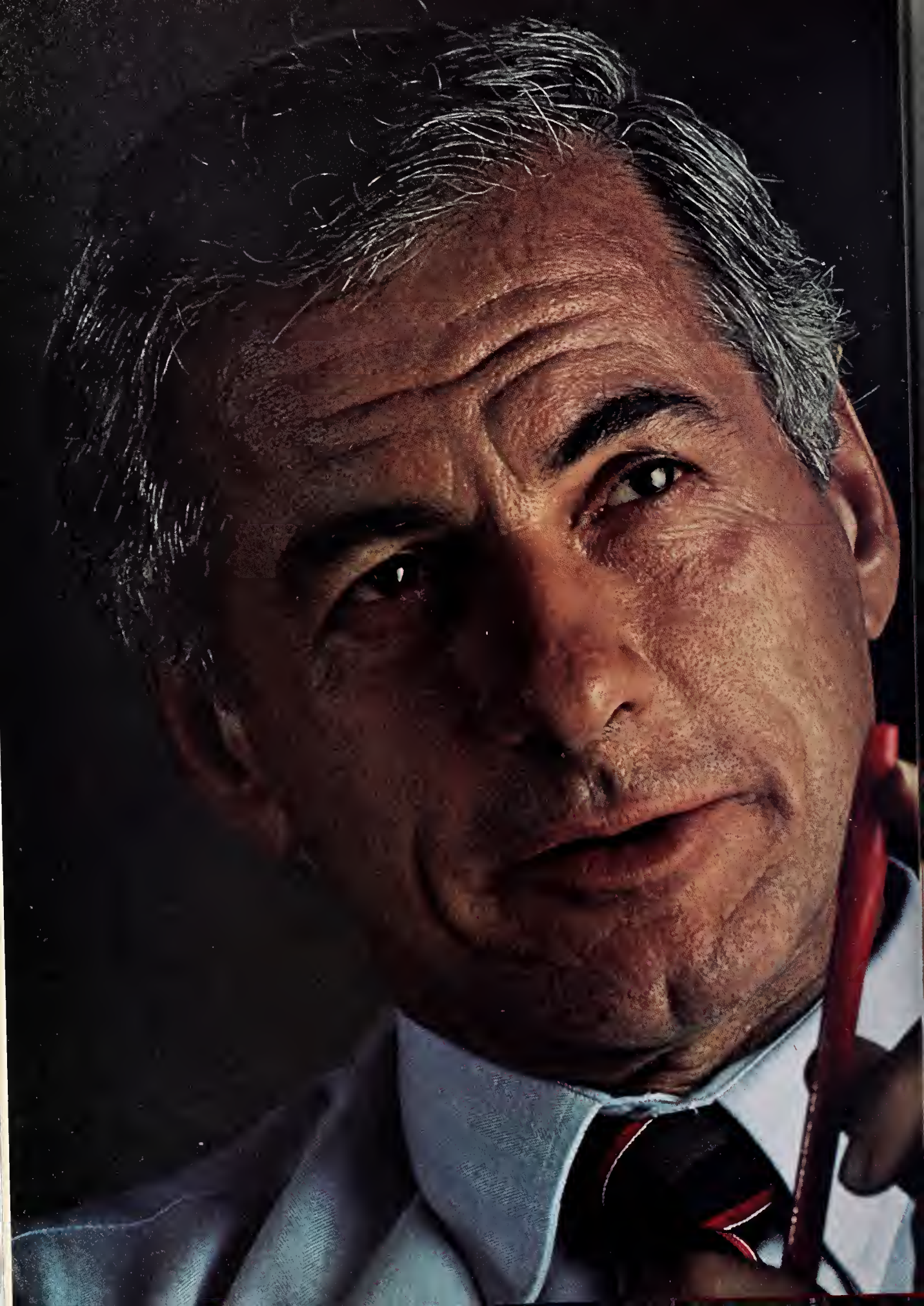
In the early seventies, he served as Chairman of the American Board of Surgery and as President of the Central Surgical Association. In the eighties, he was both Chairman of the Board of Regents and later, president, of the American College of Surgeons.

Despite all these demands upon his time, he submitted "Surgical Grand Rounds" to the *IMJ* each month—always on time, always precise, always a gentleman. Hundreds of pages of manuscript were painstakingly edited and proofed. Dr. Beal made his contribution without remuneration or real recognition. Totally committed, he played a critical role in the Society's efforts to educate, inform and support our membership through the *Journal.*

When Dr. Beal retired, the ISMS Board of Trustees recognized his years of dedication. International reknown had produced many testimonials to his accomplishments. I decided to honor Dr. Beal through the pages of the *Journal,* for it's here that his contribution will endure and influence members of our profession in years to come.

This month's President's Page is devoted to the concept of the physician volunteer and to Dr. Beal as one of the finest we've had. John M. Beal, M.D., is now retired and living out of state. I hope that his example will inspire our members to carry on his work as an educator and physician volunteer. I hope he enjoys his retirement; he earned it.

Robert C. Hamilton, M.D.
President



"When the Ayerst rep told me it costs about 45¢ a day, I said you can stop right there."

Most doctors are pleasantly surprised to learn that the average cost of daily therapy with the world's most widely used beta blocker is so little, not much more than the cost of a daily newspaper.

When it's INDERAL tablets (propranolol hydrochloride) you want for your hypertension patients, remember to specify Dispense As Written (DAW) or Do Not Substitute on your prescriptions. That way, you can always be assured they'll get INDERAL®.

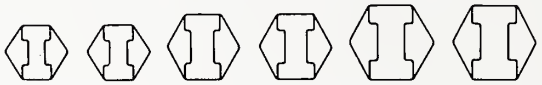
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"When the Ayerst rep told me it costs about 45¢ a day, I said you can stop right there."

INDERAL® TABLETS
(PROPRANOLOL HCl)



10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL: In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC: Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing; at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetic).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml• hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL (propranolol hydrochloride) should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

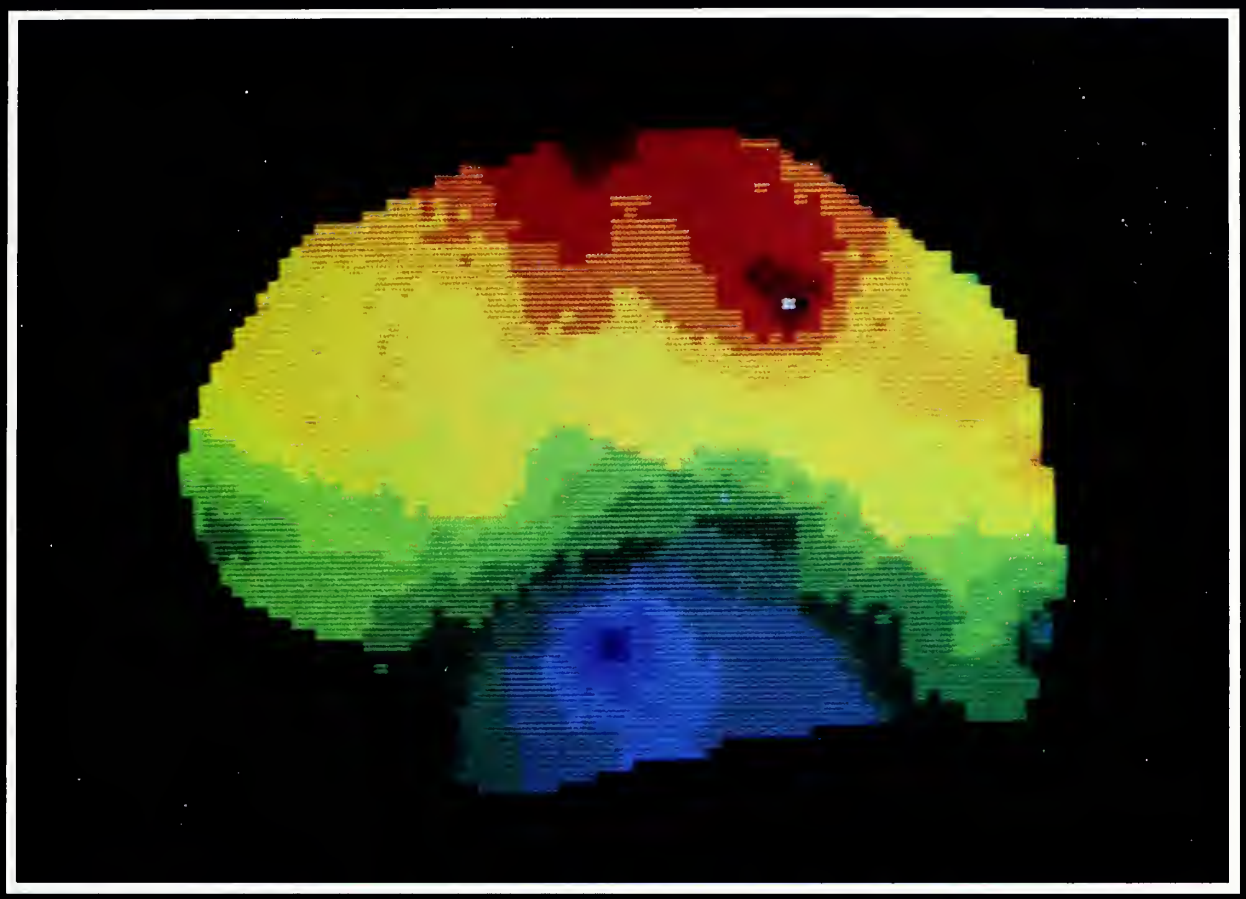
Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laboratories

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Computer generated spectral analysis of EEG.

ANXIO-SELECTIVE

Tranxene possesses an anxioselective profile:

Anxioselectivity reflects the potential of a tranquilizing agent to provide selective relief of anxiety symptoms with a minimum of unwanted effects.

Tranxene acts rapidly[1] and calms effectively: studies report between 83% and 96% positive therapeutic response.[2] Yet problem sedation* is infrequent.[3-11] And there is little likelihood of anterograde amnesia[12,13] or of rebound problems associated with abrupt decline in serum levels.[14,15] Though most Tranxene studies have not been specifically designed to investigate amnesia or rebound phenomena, the record is impressive. In more than a decade there have been no reports in the medical literature linking Tranxene to such problems.

*Problem sedation is defined as moderate to severe degrees of sedation, sleepiness, drowsiness, lassitude.

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TRUST TRANXENE®

CLORAZEPATE DIPOTASSIUM Ⓒ IV

TO LEND A HELPING HAND
TO THE ANXIOUS PATIENT

See accompanying prescribing information and references.

Brief Summary of Prescribing Information

INDICATIONS — For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS — Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits). **Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibillty of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy.** Do not give to nursing mothers.

PRECAUTIONS — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE — Take general measures as for any CNS depressant.

SUPPLIED — TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

REFERENCES

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ABSTRACTS OF ACTIONS

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

September 15, 1984

The Hamilton Hotel
Itasca, Illinois

MEDICARE FEE FREEZE

President Reagan has signed into law the Medicare/Medicaid Budget Reconciliation Amendments of 1984 (HR 4170). This includes a freeze on increases in physicians fees for a 15-month period from July 1, 1984 to October 1, 1985. The Board voted to request a 90 day delay in the implementation of this program in order to better inform physicians.

BLUE CROSS/BLUE SHIELD PROGRAMS

Blue Cross/Blue Shield has implemented the following three new programs pertaining to physicians:

Mandatory Additional Surgical Opinion

The goal of this program is to provide patients with additional information. A second surgical opinion will be considered a covered benefit for several elective procedures. Failure to obtain an additional surgical opinion when the mandatory program is in effect will result in a lesser payment for the surgery, thereby placing the financial responsibility on the Blue Shield member.

Mandatory Out-Patient Surgery

This program provides that 65 specified procedures are not covered unless performed in an out-patient setting.

Pre-Admission Review

This program calls for a Pre-Admission Review form to be completed and sent to the Blue Cross/Blue Shield Medical Department for approval when a patient with one of the 65 specified procedures on the out-patient surgery list needs to be admitted on an in-patient basis.

The Board: (A) Charged the Council on Economics with monitoring the three new Blue Cross/Blue Shield programs; (B) Authorized the formation of a liaison sub-committee under the Council on Economics for reporting purposes; (C) Agreed that BC/BS representatives may serve as consultants; and (D) Agreed that ISMS President serve as consultant.

OFFICE OF CONTRACTUAL SERVICES

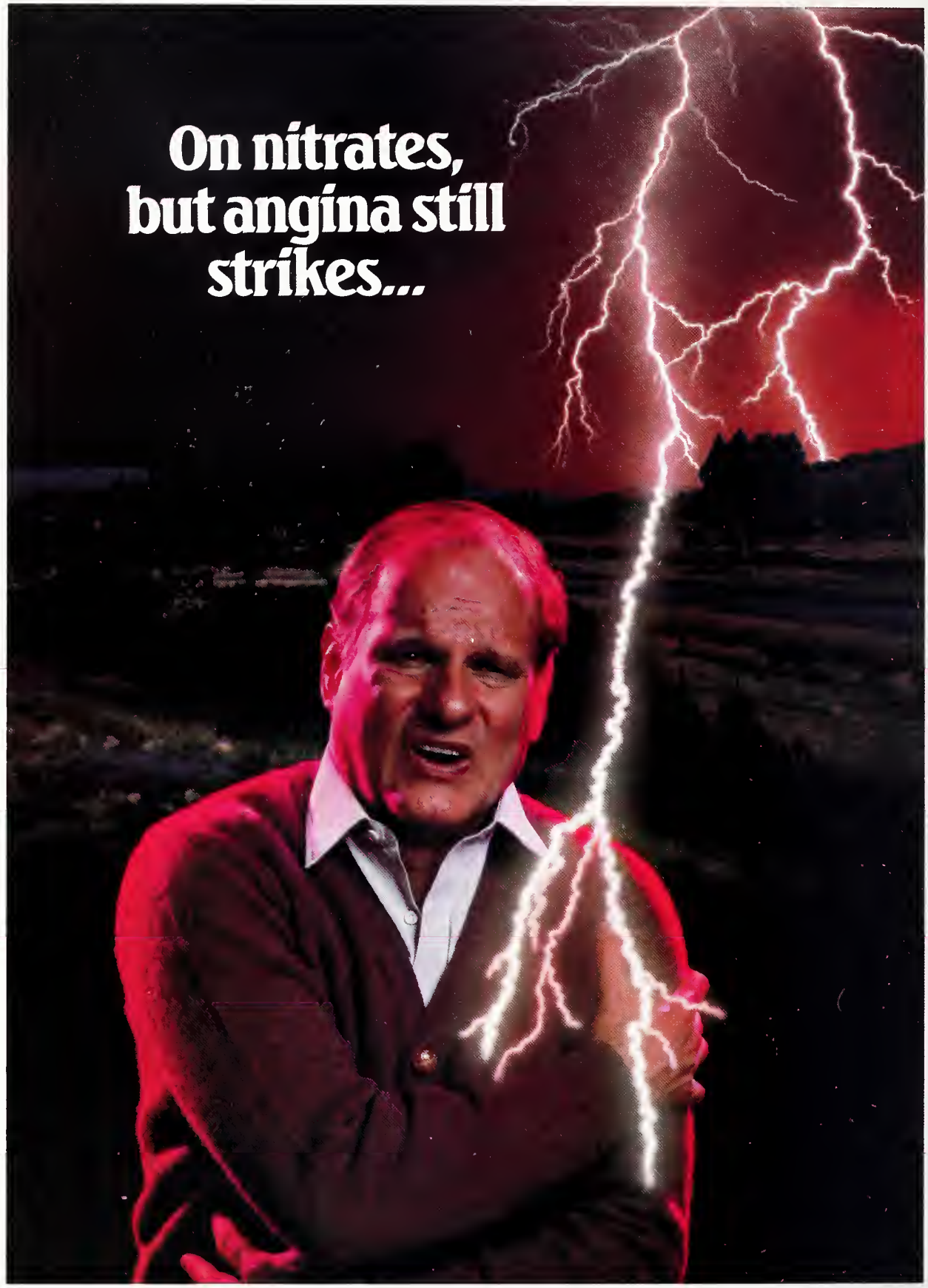
Physicians are faced with a multitude of legal matters, one of the most perplexing of which is review of contracts. Various contracts are offered between hospitals and physicians, and there are other contractual arrangements in the context of HMO, PPO, IPA, HPO or other alternative delivery systems. In response to the needs of physicians pertaining to contract review, the Board endorsed establishing an ISMS Office of Contractual Services. The Board also accepted a proposal to develop legal services for the membership regarding physician contracting under alternative health care delivery systems.

PACRS PROGRAM

Responding to a request from a county medical society to review PACRS (pre-admission and concurrent review service) the Council on Economics reported that under the terms of this program, a patient is required to obtain information from a physician indicating the diagnosis/surgical procedure to be performed, a description of the need for the hospitalization and the expected length of stay. The patient is then required to inform PACRS and obtain approval for the proposed length of stay. The Council expressed concern that patients affected by PACRS may not fully understand the plan or their responsibilities and obligations under the plan. Further, the council believes that any pre-admission review/certification should be performed at the local level.

In response to this, the Board directed that a letter be forwarded to carriers using a PACRS system urging that they: (A) More adequately inform patients of PACRS and their obligations under this plan; and (B) Involve local physicians in the evaluation and review of proposed lengths of stay.

(Continued on page 321)


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

A preliminary multicenter trial evaluated blood glucose control with the evolution of diabetic retinopathy and albuminuria. Seventy patients with similar demographic, clinical and glycemic characteristics were randomly assigned to continuous subcutaneous insulin infusion or conventional injection treatments. During the eight month study, the glucose levels were elevated in the conventional treatment group and dropped to nearly normal level in the continuous infusion group. Hypoglycemic episodes occured in equal frequency between the two groups, but ketoacidosis occured only in the group with continuous infusion. The elevated albumin excretion diminished in the cases with continuous infusion but not in the conventionally treated group. Retinopathy progressed in both groups, possibly more in the group treated by continuous infusion. (Kroc Collaborative Study Grp, *NEJM*, 311#6:365-72, Aug. 9, 1984)

High resolution computed tomography of the lumbar spine in 80 consecutive patients with lower back pain was correlated with electromyography. These were followed for one year. The CT and EMG often agreed but myelography and/or surgery confirmed the abnormality only at the level demonstrated on EMG. The authors concluded that an abnormal EMG seems to correlate better with the demonstrated course of radiculopathy than the CT. (Kahtri, B.O. *et al: Arch Neurol* 41:954-7, June 1984)

Epidurally administered morphine at doses of 0.12 mg/kg elicited analgesia for about 10 hours in nine pediatric postoperative patients. Catheters remained for approximately 50.3 +/− 16 hours, without complications, reduced the total requirements for narcotics and the quality of reduced pain, improved pulmonary function and permitted earlier ambulation. (Glenski, J.A. *et al: Mayo Clin Proc.* 59#8:530-3, Aug. 1984)

An analysis on 8006 subjects with history of alcoholism revealed an increased incidence of rectal cancer in men whose monthly consumption of beer was 15 liters or more, and an increased incidence of lung cancer in men who consumed an excess of wine or whiskey. This data was adjusted for age and for cigarette smoking. (Pollack, E.S., *et al, NEJM* 310#10:617-21, March 8, 1984)

Thirty nine patients with neurogenic dysfunctions requiring intermittent catheterizations were grouped into a placebo group and a methenamine mandelate treated group with urinary acidification. The incidence of urinary tract infection was 86% within the placebo treated group and 53% in the mandelamine and acidification treated group. Gram positive cocci and pseudomonas species were markedly reduced in the drug treated group. (Kevorkian, C.G., *et al: Mayo Clin Proc.* 59#8:523-9, Aug. 1984)

An epidemiologic survey in 5303 school children between 10-14 years of age showed an incidence of scoliosis in 7.1% with a curve between five and nine degrees. Radiographic measurements showed pelvic asymmetry, leg length inequality and frequently both. Idiopathic scoliosis in the thoracolumbar or lumbar region should exclude pelvic tilt scoliosis by radiographic evaluations. Twenty five percent of normal adolescents have clinical evidence of a spinal deformity on bending foreward, and 40% of these are secondary to pelvic tilt. (Walker, A.P., Dickson, R.A.: *Lancet* #8395:152-4, July 21, 1984)

Twenty six children of 79 asthmatics had prodromal itching 1-30 minutes before attacks, and 17 noted itching during the early phase of asthmatic attacks. The site of itching was constant for each child; the anterior neck was cited in 14 and the upper part of the back in nine patients. This phenomenon may be of diagnostic use when taking a history and may enable the physician to abort or treat an attack of asthma more promptly. (David, T.J., *et al, The Lancet* #8395:154-5, July 21, 1984)

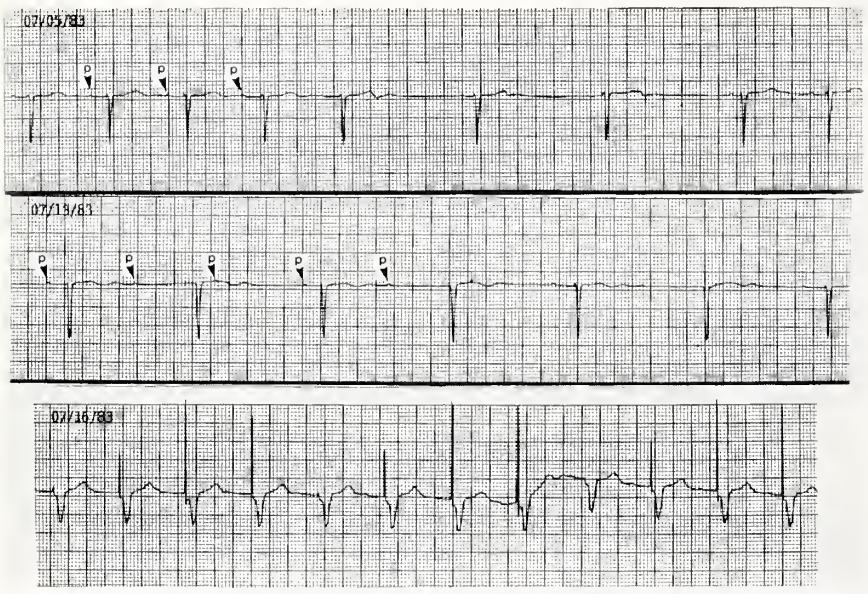
The most common cause of floaters in the eye is age-related degeneration of the vitreous, characterized by liquefaction and fibrillar degeneration. Pockets of liquid vitreous collect between the retina and the vitreous gel with the vitreous collapse. This occurs in approximately 50% of people over 50 yrs of age, earlier in myopic persons. Hemorrhages may be responsible in patients with proliferative diabetic retinopathy, in hypertensives, retinoblastomas and in inflammatory diseases. Patients with acute onset of floaters should have an ophthalmologic consultation as soon as possible. (Laibovitz, R.A.: *Postgrad Med*, 75#5, April 1984)

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This month's ECG was submitted by Drs. Helen Gartner Martin, Robert J. Havey, and Gary J. Martin, Department of Medicine, Northwestern University Medical Center

A 76 year old white male with a history of aortic stenosis and aortic insufficiency had been feeling well until two days after an extensive dental procedure when he noted the onset of fever and chills. His fever persisted despite outpatient antiobiotics and he was admitted to the hospital a month later. Treatment of bacterial endocarditis due to a group B beta hemolytic streptococcus was initiated. An echocardiogram revealed a vegetation on the anterior leaflet of the aortic valve. The patient was treated with aqueous penicillin G, 12 million units/day for six weeks. He did well for approximately one year but returned in July, 1983 with a two week history of fever to 103° and chills. He denied any dental, urologic, or gastrointestinal procedure since his 1982 hospital admission. On admission, his physical exam revealed a blood pressure of 120/60mmHg with a regular pulse of 80/minute. His lungs were clear. He had a delayed carotid upstroke on cardiac exam, a normal S1 and S2, a III/VI systolic murmur heard throughout the precordium radiating to both carotids, and a II/VI diastolic blow heard best at the left sternal border. His ECG on admission was unchanged from the previous year and revealed a first degree AV block, nonconducted premature atrial beats, and runs of premature atrial beats in bigeminy. Chest X-ray revealed cardiomegaly with pulmonary vascular congestion. Five of seven blood cultures grew staphylococcus epidermidis and he was started on parenteral penicillin. Blood cultures became negative on penicillin therapy but on his eighth hospital day, he developed severe congestive heart failure. These three ECG strips were taken over the next few days.

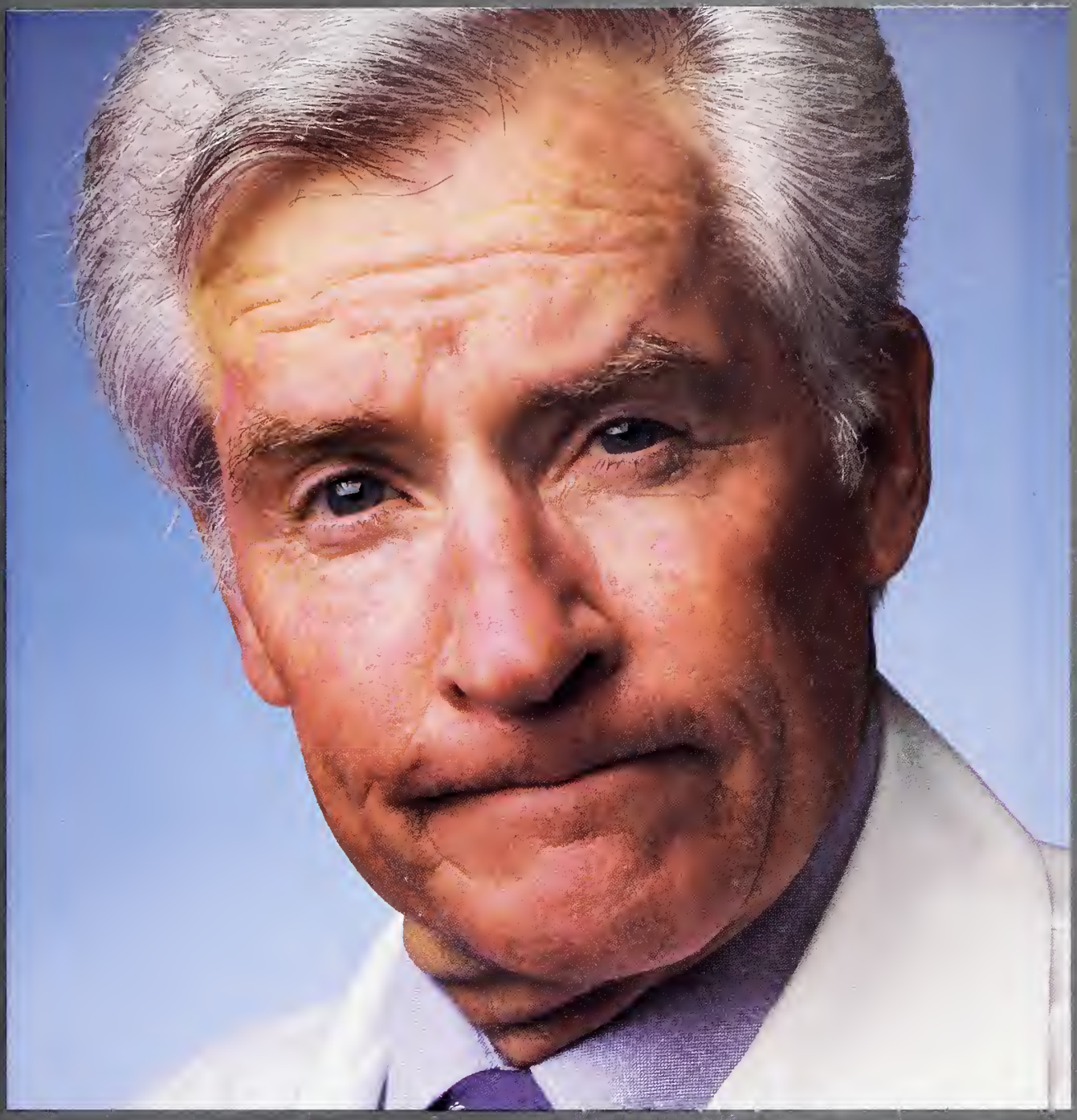


Questions:

1. **The three separate ECG strips show:**
 a. Sinus rhythm with advanced atrioventricular (AV) block.
 b. AV dissociation caused by third degree AV block.
 c. Accelerated idioventricular rhythm.
 d. Malfunctioning pacemaker.
 e. All of the above.

2. **The following statement(s) is/are true:**
 a. Heart block associated with infective endocarditis is common.
 b. Heart block associated with infective endocarditis is strong evidence for a valve ring abscess.
 c. Heart surgery is indicated here.
 d. A pacemaker is *not* needed in this case.

(Continued on page 378)



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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

DECEMBER

Internal Medicine
Management of Difficult Arrhythmias
For: MDs. Symposium, December 7, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, IL 62708. **Fee:** TBD. **Reg. Limit:** TBD. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711

Advanced Trauma Life Support Providers Course
For: MDs. Workshop, December 13-14, Springfield. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, IL 62708. **Fee:** TBD. **Reg. Limit:** 16. **Credit:** Category 1, TBD. **Contact:** Charles E. Osborne, Ed.D., Asst. Dean for CME. **Phone:** 217-782-7711

Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, December 17, 4:30-6:30PM, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064. **Fee:** None. **Reg. Limit:** None. **Credit:** None. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

Orthopedic Surgery
Low Back and Sciatic Pain: Evaluation and Treatment
For: MDs. Seminar, December 7-8, St. Louis. **Sponsor:** Washington University School of Medicine, Box 8063, 660 South Euclid, St. Louis. **Fee:** $200. **Reg. Limit:** 150. **Credit:** AAFP Prescribed: 14.5 hrs.; AMA Category 1: 14.5 hrs.; AOA: 14.5 hrs. **Contact:** Loretta Giacoletto, Admin. Coord'r. **Phone:** 800-325-9862 or 314-362-6893

Neurology
The Second Comprehensive Neuroimmunology Conference
For: Neurologists. Course, December 5-8, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** $300.00. **Reg. Limit:** None. **Credit:** Category 1, 24 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Neurology for the Non-Neurologist
For: MDs. Course Review, December 12-14, The Westin Hotel, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, University Office of Continuing Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** $350.00. **Reg. Limit:** None. **Credit:** AAFP Elective, 20 hrs. **Contact:** Barbara Trejo. **Phone:** 312-942-7119

Pediatrics
Current Problems in Pediatrics
For: MDs. Lecture, December 3-7, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood, Chicago, IL 60612. **Fee:** $540.00. **Reg. Limit:** 90. **Credit:** Category 1, 40 hrs., Other: PREP. **Contact:** Robert J. Baker, MD. **Phone:** 312-633-2600

Sports Medicine
2nd Annual Hawkeye Sports Medicine Symposium
For: MDs, RNs, PTs, PAs. Symposium, December 6-8, 8-5pm, Iowa City, Iowa. **Sponsor:** The University of Iowa College of Medicine, 285 ML, Iowa City, IA 52242. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBA. **Contact:** Deborah L. Hatz. **Phone:** 319-353-5763

Cardiology
New Approaches to Management of Profound Congestive Heart Failure. The 4th Annual Conference on Heart Diseases
For: MDs. Lectures, Workshops, December 7-8, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, 465b WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, 10 hrs. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Pathology
A Pathologist View: 1) Relationship Between Gastro-Esophageal Reflux, Bronchial Asthma and Barrett's Epithelium; and 2) Histochemical and Immunocytochemical Aspects of Gastric Dysplasias and Neoplasias
For: Pathologists. Lecture, December 10, 7:00 pm., Drake Hotel, Chicago, IL. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central Ave., Chicago, Illinois 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312-626-4300

Gynecology
Problem Solving in Gynecologic Endocrinology and Infertility
For: MDs. Course, December 7-8, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago 60637. **Fee:** $250.00 **Reg. Limit:** None. **Credit:** Category 1, 10 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

JANUARY

Surgery
Specialty Review in Thoracic Surgery
For: MDs. Lecture, January 7-12, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $600.00. **Reg. Limit:** TBA. **Credit:** Category 1, 46 hours. **Contact:** Robert J. Baker, MD. **Phone:** 800-621-4649

Specialty Review in General Surgery, Part II
For: MDs. Lecture, January 29-February 8, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $750.00. **Reg. Limit:** TBA. **Credit:** Category 1, 100 hours. **Contact:** Robert J. Baker, MD. **Phone:** 800-621-4649

Cardiology
Modern Cardiology and Technology
For: Cardiologists, MDs. Lecture, January 16, 23 and 30, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $100.00 **Reg. Limit:** 90. **Credit:** Category 1, TBA. **Contact:** Robert J. Baker, MD. **Phone:** 800-621-4649

Nutrition
A.S.P.E.N.'s Annual 9th Clinical Congress
For: MDs. 9th Clinical Congress, January 21-24, Miami Beach, Florida. **Sponsor:** The American Society of Parenteral and Enteral Nutrition, 1025 Vermont Ave., N.W., Washington, D.C. 20005. **Fee:** $120-250. **Reg. Limit:** None. **Credit:** Category 1, 25 hours. **Contact:** Donna M. Baudrau. **Phone:** 202-638-5881

Allergy
Impact on Health Maintenance Organizations on Allergy Practice-Present and Future
For: Allergists. Lecture, January 21, 8:00 pm, Holiday Inn, Chicago. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Highway, Mount Prospect, Illinois 60056. **Fee:** $15.00. **Reg. Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312-255-1024

Radiology
Update in Radiology
For: MDs. Symposium, January 10, 1:00-5:00 pm, Lincoln, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee:** $45.00 **Reg. Limit:** None. **Credit:** Category 1, 4 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

General Medicine
Medical Seminar-at-Sea
For: MDs. Seminar, January 19-30, Caribbean Cruise. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee:** $500.00 **Reg. Limit:** None. **Credit:** Category 1, 48 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

Pathology
Hyperlipidemia
For: Pathologists. Symposium, January 14, 1985 at 7:00 pm., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, 645 S. Central Avenue, Chicago, 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hrs. **Contact:** Marshall Short, MD. **Phone:** 312-626-4300.

FEBRUARY

Allergy
Regional Concept of Botany of Midwest
For: Allergists. Lecture and case presentations, February 17, Chicago. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 East Northwest Highway, Suite 101, Mount Prospect, 60056. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, 5 hrs. **Contact:** Diane K. Kubis. **Phone:** 312-255-1024.

General Medicine
Medical Seminar-at-Sea
For: MDs, Surgeons. Seminar, February 15-March 3, Panama Trans-Canal Cruise. **Sponsor:** Southern Illinois University School of Medicine, Post Office Box 3926, Springfield, 62708. **Fee:** $600. **Reg. Limit:** TBD. **Credit:** Category 1, 66 hrs. **Contact:** Charles Osborne, Ed. D., Assistant Dean for Continuing Medical Education. **Phone:** 217-782-7711.

Advances in Family Medicine
For: MDs. Lecture, February 11-15, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $500. **Reg. Limit:** 90. **Credit:** Category 1, 35 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Neurology
The Biologic Basis of Neurology and Psychiatry
For: Neurologists, Psychiatrists. Lecture, February 25-March 1, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $570. **Reg. Limit:** 90. **Credit:** Category 1, 42 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Pathology
The Pathologist's Roll as a Clinical Consultant in Laboratory Medicine
For: Pathologists. Lecture, February 11, Chicago. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 South Central Avenue, Chicago, 60644-9987. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hrs. **Contact:** Marshall H. Short, M.D. **Phone:** 312-626-4300, Ext. 5720.

Surgery
Review Course in Neurological Surgery
For: Neurosurgeons, Neurologists. Lecture, February 1-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $750. **Reg. Limit:** None. **Credit:** Category 1, 101 hrs. **Contact:** Robert J. Baker, MD., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, February 25-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $490.00. **Reg. Limit:** 15. **Credit:** Category 1, 16 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.


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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

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CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL. In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC. Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing, at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetics).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml•hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL (propranolol hydrochloride) should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure, intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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Abstracts of Board Actions

(Continued from page 311)

UCR POLICY

Agreed to introduce the following resolution to the next session of the House of Delegates to delete the policy statement on "Usual and Customary or Reasonable Reimbursement," in light of current House policy.

WHEREAS, The Board of Trustees introduced and the House of Delegates adopted ISMS Resolution 4(A-84) which states that ISMS:

(1) Supports the individual physician's right to choose the method of economic reimbursement for care that best suits the needs of that physician and his/her patients, in order to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician and his/her patients; (2) Support, where appropriate, the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays; and (3) Strive, to the extent practicable, to assist physicians in understanding alternative reimbursement systems; and

WHEREAS, the 1979 policy statement states that: The Illinois State Medical Society endorses the AMA policy on physician reimbursement which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule; and

WHEREAS, These two statements appear to be in conflict; therefore be it

RESOLVED, That for reasons of consistency, the policy statement on Usual Customary and Reasonable Reimbursement be deleted from the ISMS Policy Manual.

STUDENT LOAN FUND

The Board authorized that: (1) $75,000 be released from the Illinois State Medical Society student loan fund account for the purpose of providing student loans to eight Illinois medical schools for the academic year 1984-85 in the following increments: University of Chicago, $8,722; Loyola University, $8,596; Rush Medical College, $9,142; Chicago College of Osteopathic Medicine, $6,923; Northwestern University Medical School, $11,417; University of Illinois Medical School, $12,768; Southern Illinois University, $5,000; and Chicago Medical School, $12,432; and (2) Service charges be set for loans assigned to students for 1984-85 at 5.5% to allow for basic administrative costs of the program.

DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Glucotrol (Glipizide) 5mg tablet and 10mg tablet; Monocid (Cefonicid) 500mg vial and 1gm vial; Capoten (Captopril) 25 mg tablet, 50mg tablet and 100mg tablet; and Theo-Dur Sprinkle (Theophylline, Anhydrous Sustained Release) 50mg capsule, 75mg capsule and 125 mg capsule.

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Bancap-HC (Acetaminophen; Hydrocodone Bitartrate) 500mg capsule and 5mg capsule; Aldactone (Spironolactone) 50mg tablet; Aldactazide (Spironolactone; Hydrochlorothiazide) 50mg tablet; Lanoxicaps (Digoxin Solution) 0.05mg capsule, 0.1mg capsule and 0.2mg capsule and Hydrocil (Psyllium) Powder.

The Board further recommended that Theo-Dur Sprinkle in the 250mg Sustained Release dosage form be restored to the IDPA Drug Program.

POLICY COMMITTEE

Upon recommendation of the Policy Committee, based upon actions taken by the House of Delegates at its 1984 annual meeting, the Board approved the following policy statements for inclusion in the Policy Manual: (Language will be reflected in the 1984 Policy Manual).

New Policies

- Reimbursement, Physician
- Infants Born with Disabilities, Care and Treatment of
- Physician Records, Privacy of
- Drinking Age, Legal
- Physician-Patient Relationship
- Chronic Care Patients
- Newborns, Prenatal Development of
- CPR and First Aid Training for Health Club Employees, Mandatory
- Fees, Informing Patients of
- DRG Payments and Cost of Procedures
- Provider Organizations, Exclusive

Amendments to Existing Policies

- Continuing Education
- Autopsies
- Immunization Programs
- Blood Services
- Patient Care Records and their Availability
- Smoking

OTHER ACTIONS

In addressing various other issues, the Board:

- Approved the program schedule and budget for the November 10-11, 1984, Leadership Conference.
- Reaffirmed the ISMS position that UR should be accomplished only by physicians.
- Ratified holding the 1986 House of Delegates meeting at the Westin O'Hare on April 4-6, 1986.
- Agreed to consider holding the 1987 fall meeting at the Hilton Hotel in Collinsville.
- Agreed to request the AMA to share the findings of the Johns Hopkins study on DRG which are specific to Illinois with ISMS when it is available.
- Directed that a draft describing the current position of the Federal Trade Commission and ISMS Legal Counsel opinions regarding fee adjudication be sent to all county medical societies with descriptive comments added indicating author of specific criteria. The Board also agreed to ask for county medical societies' comments.
- Directed that ISMS go on record as desiring a maximum of physician input into the organization and activities of the new Department of Alcoholism and Substance Abuse.
- Approved: (1) Proposed guidelines for a Physician Support Group as a service to Illinois physicians who are going through malpractice litigation; and (2) That this be considered a pilot program to extend for one year.
- Approved the distribution of 1,300 copies of each issue of Antidote to the New Mexico Physicians Mutual Liability Company for a fee of $100 per issue to cover production and mailing costs.
- Referred back to the Committee on Hospital Medical Staffs for further delineation a recommendation that the Board: (A) Permit the Committee on Hospital Medical Staffs to annually select its own chairman; (B) Review and appoint the membership of the Committee on Hospital Medical Staffs at the first Board meeting following the Annual AMA/HMSS meeting; and (C) Not apply the limitation of five years' consecutive service to the Committee on Hospital Medical Staffs.
- Selected two current alternates, Drs. Andrew Brislen, Chicago, and Allan Goslin, Streator, to be credentialed as AMA delegates until the next ISMS Annual Meeting.
- Approved the "Criteria for Rationale in Selecting Health Professions Groups to Consult with the Task Force" for use by the Task Force in selecting groups of health professions to discuss areas of mutual interest and concern.
- Accepted an ISMIE Board of Governor's recommendation that a group be formed to study the issues of channeling, liability considerations in physician contracting, alternative delivery systems and the effect these have on physicians and the profession. The study group will be made up of knowledgeable physicians and staff appointed by the chairmen of ISMS, ISMIE and ISMIS, with appropriate representation from other entities in the state representing the medical profession.
- Agreed to attempt to monitor claims data related to DRGs.
- Ratified the 1985 advertising rates set by the Publications Committee and approved by the Chairman of the Board, as agreed in an action taken at the June 9, 1984 BOT meeting.
- Effected no changes in the 1985 IMJ subscription rates.
- Adopted "Principles Governing Advertising in the Illinois Medical Journal."
- Agreed to study a mechanism by which the Resident Physicians Section could have a permanent slot on the Illinois AMA Delegation in order that the current resident-held position be filled by resident physicians in future years.
- Referred a request from the Medical Student Section Chairman to the Committee for the Impaired Physician with legal counsel input to study appointment of a student to that Committee.
- Agreed to contact Illinois Senators and Congressmen and voice opposition to the proposal that DRG payments to teaching hospitals would pay for graduate medical education at the internship level only and reiterate ISMS' position which supports the concept of graduate medical education and which recognizes that services performed in a teaching hospital often cost more than similar services in a non-teaching patient-care setting.
- Approved the creation of an Advisory Panel to the Attorney General to review Medicaid fraud, consisting of five physicians and representatives of the Attorney General's Office and the public at large, and agreed to jointly announce the creation of the Panel with the Attorney General.
- Referred to Finance Committee for recommendation, the Council on Public Relations and Membership Services' request that the Board of Trustees: (A) Waive the back dues requirement for the 1985 membership year; and (B) Monitor membership totals to see whether or not these totals increase during the moratorium.
- Directed that the Council on Public Relations and Membership Services inform all members through appropriate ISMS publications of how exempt status is attained, and that members eligible for emeritus status be informed by letter.
- Referred a recommendation back to the Council on Education and Manpower for further study and a fiscal note, a proposal that: (A) A Letter be sent to Deans of all Illinois medical schools stressing that ISMS represents all aspects of the medical community; (B) Dr. Henikoff be invited to the January, 1985, meeting of the Board of Trustees, along with the executive officers of all eight Illinois medical schools; and (C) A special meeting be arranged between ISMS and the deans of the

Illinois medical schools to discuss areas of mutual interest and concern.

- Approved various legislative positions with respect to primary bills as presented by the Council.
- Agreed to advise members of ISMS that whenever a physician is requested to act as an expert in the evaluation of or testimony incident to a lawsuit, that appropriate arrangements, both mechanical and fiscal, be confirmed in writing before the services are performed.
- Agreed to inform all primary care organizations and interested public groups of the decision by the State Board of Education to eliminate: (A) Financial penalties for schools that permit non-immunized students to attend classes; and (B) Requirements that students entering the 5th and 9th grades have physician examinations; and also agreed to invite their participation in opposing any legislation to repeal these requirements.

PROGRAMS

The Board:

- Agreed to: (A) Publicize the activities of the National Commission on Correctional Health Care to Illinois physicians through an article in the *Illinois Medical Journal;* and (B) Send a letter to the 102 county sheriffs informing them of the Commission's activities and asking them if they would be interested in becoming accredited or receiving assistance in the development or improvement of their health services to inmates.
- Directed that ISMS not endorse or comment on local health fairs organized by the National Health Screening Council for Volunteer Organizations (NHSCVO), since each fair will be held or sponsored by a county or municipal organization.
- Agreed to support the conference, "Growing Free," and to send a committee representative to attend on behalf of the Society.
- Approved a research project to determine possible differences in CME participation in Illinois under both voluntary and mandatory systems of continuing education.
- Agreed to refer to the ISMIE Board of Directors approval for the development of a video-taped simulated trial for use in special malpractice/loss prevention education programs. It is estimated that production costs for this program to be done in 1985 would be approximately $5,000, including filming, location costs, editing and reproduction of several copies of the videotape.

APPOINTMENTS/NOMINATIONS

Acting on recommendations of the Councils and Executive Committee, the Board:

- Nominated Dr. Henrietta Herbolsheimer for the AMA Benjamin Rush Award for Citizenship and Community Services.
- Agreed to include Dr. Richard Quinones in the membership of the Impaired Physician Panel in Illinois, and that a resident be a regular voting member of this panel.
- Ratified the following nominations:
 Dr. Irene Caruso, Galesburg, to the Medical Disciplinary Board.
 Dr. Herbert Natof, Arlington Heights, for reappointment to the Ambulatory Surgical Treatment Center Licensing Board.
 Drs. Alfred J. Clementi and Audley F. Connor, Jr., to the Hospital Service Procurement Advisory Board.
 Mr. Robert Burger to the Illinois Health Care Cost Containment Council.

INFORMATIONAL ITEMS

- A slide presentation was shown relating to the professional liability initiative, which will be available upon request to county medical societies and hospital medical staffs.
- Mr. Robert Teeter, Market Opinion Research, reported on the surveys relating to the Professional Liability Initiative.
- The Executive Administrator reported on the Leadership Conference, meetings with the Medical Coordinator for the Medical Disciplinary Board, PPO seminars, monitoring changes in hospital staff privileges, and the move to the new headquarters office at Twenty North Michigan Avenue which has been changed from October 1 to October 20.

NEXT MEETING

The Board set the next Board of Trustees meeting for November 9-11, 1984, at the Clock Tower Inn, Rockford. ◂

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

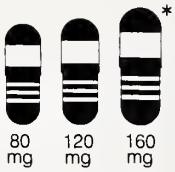
The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Just once each day for initial therapy in hypertension.

Ayerst

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.
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A Resident's Reflections on Organized Medicine

Seven years ago, the ISMS Student Business Session was involved in the process of changing its role within the state medical society from that of a session to that of a section. The SBS reorganized in order to represent the interests of all Illinois medical schools and their students within organized medicine. The SBS, originally comprised primarily of representatives from Chicago area medical schools (due to the proximity of the ISMS offices) gained active representatives from the central and southern Illinois schools and a statewide network of student participation in the ISMS evolved. Concomitantly, the Resident Physicians Section underwent a similar expansion.

During the time when these changes were taking place within the student/housestaff organizations many among them regarded organized medicine with pessimism and negativism. The AMA was viewed as a one-sided group seeking to further the interests of physicians without regard for other concerns. When the opportunity to become involved with the ISMS-SBS as a school representative presented itself, I accepted. I did so primarily in an effort to better understand this system, which others found easy to criticize. Better understanding of the ISMS prompted further participation within the system and led to an eventual involvement which had been totally unexpected.

One of the most encouraging revelations of the system has been the willingness of the ISMS to listen to student/housestaff opinion and to solicit that input actively in the various councils of the society. Through representation on ISMS councils, delegate/alternate delegate positions in the ISMS House of Delegates and reports to the board of trustees, physicians in-training have a very strong foundation from which to build a stong input into organized medicine. The same situation exists at the national level where student/housestaff positions on the AMA board of trustees were recently created.

Throughout the past seven years, I have seen many issues come before the county/state/national medical organizations. The outcome has been strongly or primarily influenced by the input of the physicians-in-training. Initial critiques of organized medicine voiced by medical school colleagues were certainly based out of ignorance of the system and a misunderstanding of its aims. The most significant aspect of organized medicine in this country lies in the fact that, with active participation, the physician-in-training today can help to mold the system of tomorrow. ◂

John M. Diveris, M.D.
Resident Member
ISMS Council on Education
and Manpower

THE VIEWBOX

Contributing Editor Terrence C. Demos, M.D., Professor of Radiology, Department of Radiology, Loyola University Stritch School of Medicine

These three previously healthy patients have had intermittent diarrhea for several months. The first patient (Figure 1) is a 65 year old woman. The second patient (Figure 2) is a 35 year old man. The third patient (Figure 3) is a 38 year old man.



Figure 1: Barium study shows multiple defects of the stomach. Many contain small collections of barium.

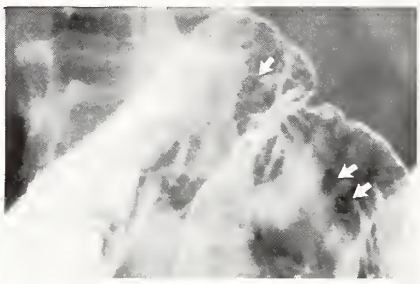


Figure 2: Barium study shows tiny ulcers (arrows) of the duodenum and stomach.

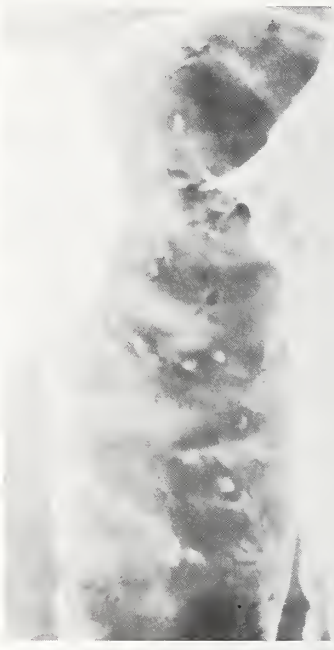


Figure 3: Air-contrast barium enema: there are several ulcers of the hepatic flexure.

Your diagnosis?

a. Normal lymphofollicular pattern
b. Ischemic bowel
c. Candidiasis
d. Crohn's disease
e. Ulcerative colitis

(Continued on page 360)

Biographical Notes

Max Thorek

By Sharon Romm, M.D./Lexington, Kentucky

Max Thorek, (Figure 1) a charismatic and energetic surgeon, is remembered for important contributions to his profession and his community. Respected for his intelligence and acclaimed for his warm and expansive personality, Thorek always displayed genuine concern for patients and colleagues alike. He was a teacher, a skilled technician, and a writer. His original work advanced both the art and science of surgery.

Born in a small town in Hungary in 1880, Thorek's father was a physician of comfortable, but not extravagant means. As a young man, Thorek attended the university in Budapest. When visiting his home town during a spring vacation, he witnessed a "pogrom"—the Jews of the town were slaughtered without reason. In this devastating episode, his brother was killed and, as a result, the remainder of the family elected to leave, emigrating to the United States.[1]

Arriving in Chicago in 1898 with no money, Thorek was anxious to succeed in his new country. Although he lacked fluency in English, he played the violin with talent which enabled him to find a job with Boguslawsky's Gypsy Orchestra, an organization which had but few authentic Gypsies on its payroll.

Calling upon his ingenuity, Thorek financed his own medical education. A scholarship was offered to the student who played the snare drums for the University of Chicago Band. Thorek's interest quickly turned to drumming and he was soon able to pay his tuition at the Rush Medical School.[2]

Thorek's first intention was to specialize in obstetrics. He interned at the Marcy Home, located in the poorest section of Chicago. Sleep was made impossible on his first night on call by the hoards of bedbugs sharing his sleeping quarters. In the nights that followed, he found a method of eliminating his tormentors: he doused himself with a solution containing carbolic acid before retiring to bed.

Thorek completed training and established a practice of general medicine in Chicago's West Side. After several years, his interest turned from medicine to surgery. He never regretted his experience as a general practitioner; he felt strongly that what is learned in such a practice is prerequisite for specialization.

In 1908, Thorek joined forces with a colleague and together they founded the American Hospital of Chicago, an institution for which



Figure 1. Max Thorek.[5]

Thorek served as surgeon-in-chief until the end of his life. Thorek encouraged theatrical performers travelling through Chicago to seek medical care at his hospital. He

(Continued on page 353)

A Summary of Board of Trustees Report Z (A-84)

Maternity Leave in Residency

The number of women in medicine is increasing. In 1982-83, almost one-third of medical students and one-fourth of residents were female. The years that a woman is in medical school and residency are the prime childbearing years for most women. An AMA survey of female physicians reports that one-half had their first child and one-fourth had their second child during training.

In 1978, amendments to the 1964 Civil Rights Act were passed which stated that discrimination in employment based on pregnancy was unlawful sex discrimination. Under those provisions, women experiencing pregnancy, childbirth or related medical conditions are to be treated the same as other disabled employees for all employment-related purposes, including coverage by fringe benefit programs. According to this legislation:

- Employers are not required to establish fringe benefit programs to provide benefits for pregnancy; but if disability benefits for employees exist, these must also include pregnancy as a form of "disability." This applies to sick leave as well.
- Policy and decisions on hiring, firing, promotion or reinstatement cannot be based on the premise of possible pregnancy.
- Arbitrary time limits as to when a woman must leave/return to work cannot be imposed when there are none for other forms of disability.
- On return to work, they must be credited with accumulated seniority on the same terms as those absent from work for other disabilities.

This law applies to residency programs in as much as residents are employed by a hospital. But residency training also involves unique educational issues. The current Essentials of Accredited Residencies include a recommendation that programs provide residents with a written agreement outlining benefits, including leaves and vacations.

The AMA House of Delegates has supported the establishment of part-time internships and residencies since 1965 and has addressed the issue many times since then. A resolution passed in 1979 encouraged flexible residency training programs, incorporating maternity leave and alternative schedules for pregnant housestaff.

The AMA Ad Hoc Committee on Women Physicians in Organized Medicine sent surveys to each of the 4573 residency training programs in the U.S. to find out their policies on maternity leave. Forty three percent of the respondents stated they had a specific maternity leave policy. This figure may actually be higher because some of these programs may have sick leave policies that they don't consider to be maternity leave.

Programs varied in the type of leave provided. The primary differences were in the duration of leave, the category of leave credited, and if the leave was paid. The three most common types were specific maternity leave, sick leave and vacation, and leave that was determined on an individual basis.

Other special provisions were sometimes made for pregnant residents. These included (a) modified schedules or part time residencies, (b) charging missed time to reading

electives, (c) special electives in maternal and infant health and (d) no night call in the last month of pregnancy or longer. Some of the programs included a policy for paternity leave and a few had policy for adoption leave.

The Board of Trustees challenges residency program directors to "develop a maternity leave policy that complies with federal law and allows pregnant residents to successfully complete their training and meet requirements for board eligibility . . . Flexibility is the key. The educational goals of the resident should not be compromised, nor should patient care suffer."

The Board of Trustees made the following recommendations:

1. Residency program directors should review federal law concerning maternity leave and note that for policies to be in compliance, pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled.
2. The duration of disability leave should be determined by the pregnant resident's physician, based on the individual's condition and needs.
3. The Essentials of Accredited Residencies should be amended to include maternity leave policies in the list of items included in the written agreement between the resident and the program.
4. All residency programs should develop a written policy on maternity and paternity leave for residents.
5. A residency program's written policy should include certain elements (specified in the report) about leave for pregnancy.
6. Manpower levels and scheduling should be flexible enough to allow for coverage without creating intolerable increases on other residents' work loads.
7. Residents should be able to return to their training program after disability leave without loss of training status.

For more information, refer to Board of Trustees Report Z from the 1984 AMA annual meeting.

Gail Herman
University of Illinois—Chicago



Transderm®-Nitro

(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)*

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

Do not store above 86°F (30°C)

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26)
5 mg/24 hr	25 mg	10 cm^2	7 Systems (NDC 0083-2105-07)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26)

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C84-7 (Rev. 2/84)

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information.)

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He Doesn't Do Eavesdropping

Dear Editor:

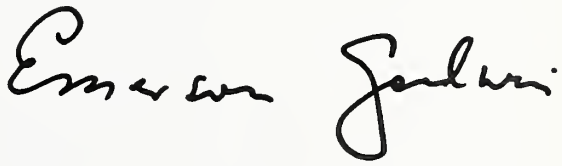
There are two classes of folks patronizing the Apollo Cafe in the forenoon. There are the regular coffee roundtable members and then there are "the rest." Conversation always flows well at the roundtable; in fact, it sometimes flows out enough to cover patrons sitting within a tablebreadth or two of the roundtable. That can be a curse for the nearby tablesitters and is occasionally used by one of the regulars attempting to influence one of "the rest."

Such an incident occurred last week when Chick, our local insurance agent, directed his comments toward the table but looped them out in the cafe to include our legislative representative, who was within the range of his voice. The comments had to do with the amount of taxes, the unfair tax structure, and the fact that most of the burden fell on his shoulders to the relief of the rest of the populace. Chick became more and more frustrated, raising his voice octaves and decibels. In spite of Chick's persistence, our trusty legislator drank his coffee, munched his sweet roll, and concentrated on faded graffiti on the far wall of the Apollo.

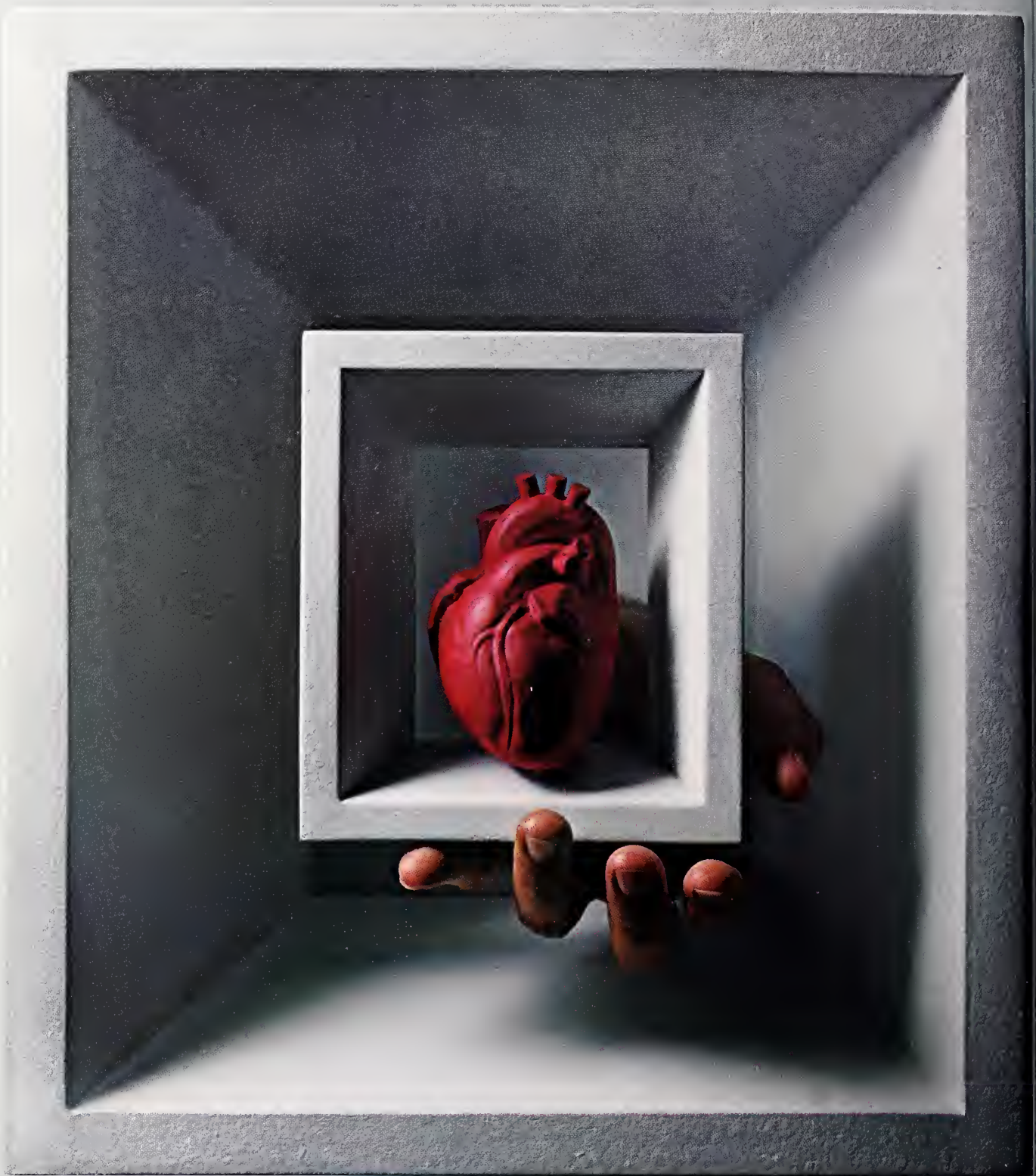
He finished all three activities at about the same time that Chick almost reached the breaking point. Chick's voice and temper were both about to break when our legislator dusted off his mouth and table and headed for the cash register. He paused at the roundtable, nodded and bid good morning to a few of the regulars, and then looking past Chick said, "One thing that folks hereabouts need to realize is that I don't do windows and I don't do eaves-dropping. If someone wants me to hear somethin', they need to talk to me. If I spent all of my time worrying about stray and misdirected comments, I wouldn't have much time for the serious business at hand." He nodded one more time and walked away with what seemed to be total aplomb. This was obviously an act, however. The degree of his somewhat controlled anger was evident when he laid his dollar on the countertop with the check and walked out without picking up his change.

This incident led to some considered discussion around the table, much to Chick's discomfort. The consensus was that that wasn't an appropriate way to make a point to a public official. It seems to me that you doctors are involved now in legislative activity that has to do with your malpractice insurance. Reading your reports, commentaries and journals, it seems to me like you're doing a lot of talking to each other right now. Your roundtable is a lot bigger than ours at the Apollo and I am sure your collective voice will be louder than even Chick's. I further suspect that some of your written and voiced words are swinging out wide throughout the state.

My concern, however, is that in order to be effective you are going to have to do more than talk to each other. Some of your conversation and discussion is going to have to be with your legislators. I don't know that your legislator has the same or different feeling than ours, but one thing I learned from that episode is that our representative in Springfield doesn't do eavesdropping. He needs to be talked to. ◂



Sincerely,
Emerson Goodwins



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) *LONG ACTING CAPSULES*

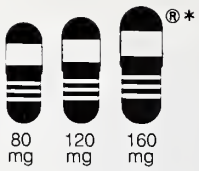


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JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
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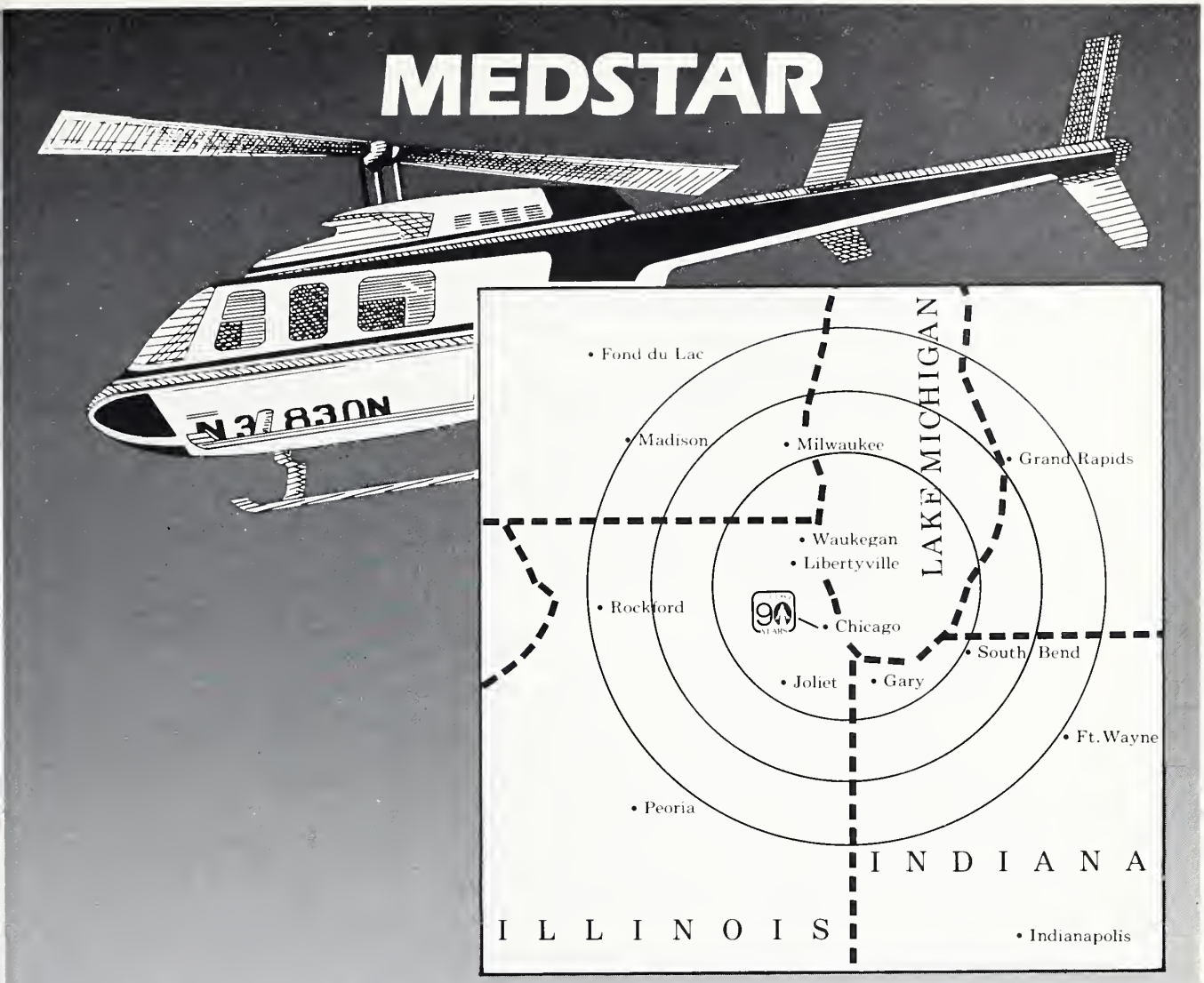
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Prostate Cancer in Illinois

By Patrick D. Guinan, M.D. Cyril C. Wiggishoff, M.D., Isadore D. Rotkin, Ph.D., Joan S. Chmiel, Ph.D., JoAnne Sylvester, M.A. and Myles P. Cunningham, M.D., /Chicago

An analysis is presented of tumor registry data covering 4,389 patients from 50 Illinois hospitals who were diagnosed with prostate cancer between 1970 and 1974. Distributions of cases of age, race, stage, method of diagnosis, survival, and modality of treatment are given. Findings include increased incidence and more advanced stages at time of diagnosis in black patients. Relative survivals for all patients correlate inversely with age and stage. Trends generally parallel those of U.S. data.

Carcinoma of the prostate is the second leading cause of mortality from cancer in United States males.[1] Although incidence rates of detected prostate cancers in U.S. black males surpassed those of all other cancers during the period under study, and were second in rank only to lung cancer in white males, frequencies in blacks exceeded those in whites by 70%.[2] Mortality rates in Illinois conform to national rates, amounting to 16% of all cancer cases in male patients during 1979.[3] Recognizing this as a major concern, and as part of an ongoing program to provide reliable end results for selected priority cancers from improved registry data, the Cancer Incidence and End Results Committee of the American Cancer Society (ACS), Illinois Division, surveyed information on prostate cancer submitted by 50 Illinois hospitals.

Procedures

Protocol consisted of a standardized report form for cases first treated at each hospital, those diagnosed but not treated at the same hospital, and those detected at autopsy. A form for each case was completed by registrars at reporting hospitals. The form also provided demographic information, data on cell type, staging, treatment, and survival experience. Review and quality control of data were maintained by staff consultants at ACS, Illinois Division.

Thirty eight hospitals from the Chicago SMSA (Standard Metropolitan Statistical Area) and 12 from the remainder of the state submitted data on 4,389 patients who were diagnosed with prostate cancer during the period from 1970 through 1974. These patients were entered into cancer registries at participating hospitals, all utilizing uniform practices and definitions for the acquisition, monitoring, maintenance and follow-up of information.

Distributions by Race and Age

Of the 4,268 Illinois patients with prostate cancer from whom racial information was available (97.2% of total), 80.4% were white and 19.5% were black. Only 4 Orientals were reported.

Distributions of cases by age and race at diagnosis revealed that 90% of the patients were age 60 and over and 60.8% were age 70 and over. Proportionately more prostate cancers were diagnosed at earlier ages, 69 years and younger, in blacks compared to whites. In the 59 and younger age group, initial diagnosis of prostate cancer was made in 12.4% of black cases compared to 9.4% of white cases, a difference that is even greater in the 60-69 age group (33.1% blacks; 28.2% whites). After adjustment to age-specific and race-specific distributions for males from 1970 Illinois census data, estimated age-specific distributions for males from 1970 Illinois census data, estimated age-specific incidence rate ratios suggest an increased risk of disease for older blacks compared to whites in the Illinois population.

Distributions by Stages, Histology, and Method of Diagnosis

Over 61% (61.2) of all patients were staged with localized diseases, 12.6% with regional disease and 21.1% with distant disease (Table 1). In blacks, 52.3% were diagnosed as localized disease and 28.5% were diagnosed as distant disease compared to 63.5% and 19%, respectively for whites, demonstrating that stage at time of diagnosis was more advanced in blacks.

Adenocarcinoma was the most frequent histologic type (88.3%), followed by carcinoma NOS (not otherwise specified) 6.8%, and transitional cell carcinoma (0.5%). No microscopic confirmation was given for 4.3% of cases. Histologic grading was obtained in only 43.8% of cases.

Histologic confirmation was made in 95.2% of cases; an encouraging outcome. Cases reported as diagnosed at autopsy numbered 176, most of which were early stage disease. On the other hand, 194 cases were clinically diagnosed and, as might be expected, distant stage disease accounted for the bulk of these cases. Results of a random sample on treatment (Table 2) show that node dissections were done only in an estimated 1% of surgical cases.

Survival by Race, Age, and Stage

Two statistical methods are used in Figure 1 to present survival information. *Observed survival* is calculated by the acturial or life table method. *Relative survival* is the ratio of the observe rate to the rate expected in the general population in a group similar to the patient group with respect to race, sex, age, and calendar period of observation. This provides an adjustment for normal mortality. Additionally, since prostate cancer is limited to older age classes, relative survival rates more accurately reflect the impact of the disease. Observed five year survival was 37.5% compared to a relative survival of 55.9%, a substantial difference.

An apparent association of race with prognosis is shown in Figure 2. White patients had a five year relative survival of 57.3% compared to blacks at 50.6%.

TABLE 1
Distribution by Stage and Race for 4,389 Prostate Cancer Patients Diagnosed at 50 Illinois Hospitals 1970-74

	All Cases		White		Black	
Stage	# of Cases	% of Cases	# of Cases	% of Cases	# of Cases	% of Cases
In Situ	35	0.8	26	0.8	9	1.1
Localized	2685	61.2	2180	63.5	435	52.3
Regional	551	12.6	410	11.9	130	15.6
Distant	925	21.1	652	19.0	237	28.5
Unknown	193	4.4	163	4.8	20	2.4
TOTALS	4389	100.0	3431	100.0	831	100.0

TABLE 2
Random Sample: 20% of Cases Initially Treated by Surgery, Radiation, or a Combination of These

	Cases			Cases	
Surgery	3 #	%	Radiation	#	%
Radical Prostatectomy/Node Dissection	6	1.0	1-4999 Rads	45	7.6
Radical Prostatectomy/No Node Dissection	23	3.9	5000+ Rads (Prostate, pelvis)	41	6.9
Radical Prostatectomy/Node Dissection Unknown	4	0.7	Dose/Site Not Available	458	77.5
Transurethral Resection (TUR)	438	74.1	None	47	8.0
Other Surgery	44	7.4			
None	76	12.9			
TOTALS	591	100.0	TOTALS	591	100.0

Figure 1

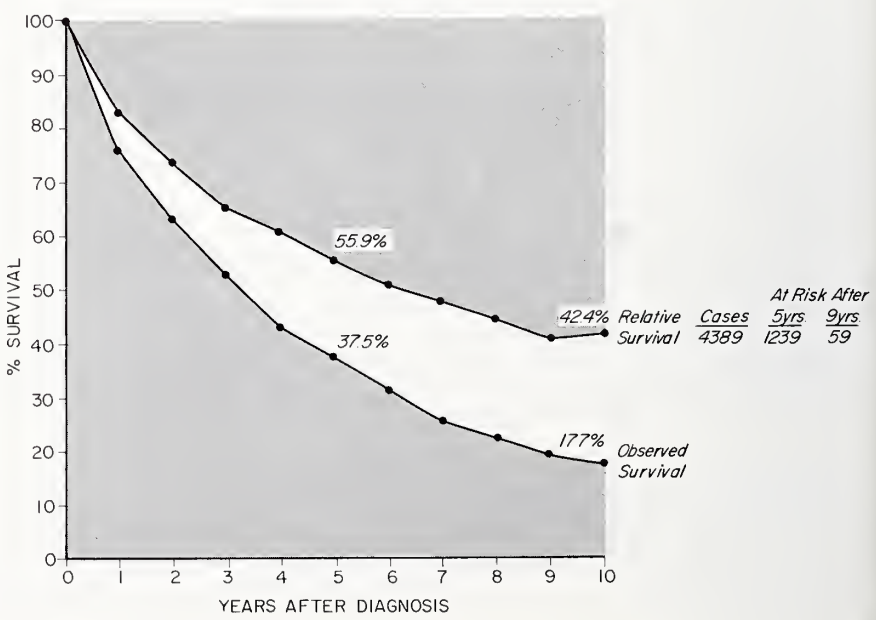


TABLE 3
Five- and Ten-Year Relative Survival by Race and Stage for 4,389 Prostate Cancer Patients Diagnosed 1970-74 at 50 Illinois Hospitals

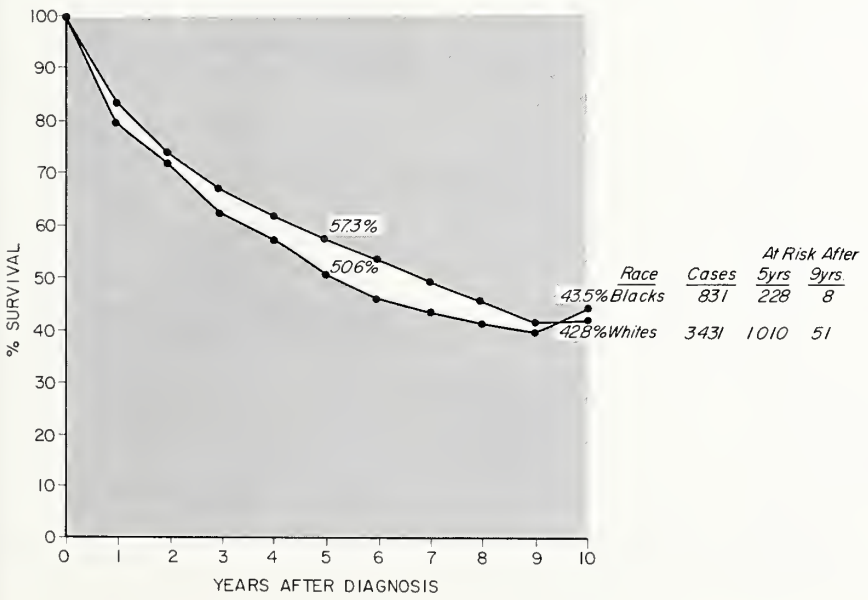
	White			Black		
		% Survival			% Survival	
	Cases	5 yr.	10 yr.*	Cases	5 yr.	10 yr.*
In Situ	26	66.8%	0.0%	9	78.0%	0.0%
Localized	2180	67.9%	53.3%	435	67.7%	62.6%
Regional	410	63.6%	60.4%	130	39.3%	24.6%
Distant	652	21.8%	8.8%	237	24.1%	0.0%
Unknown	163	44.8%	27.7%	20	68.2%	0.0%
All Stages	3431	57.3%*	42.8%	831	50.6%	43.5%

***Five year age-stage direct-adjusted relative survival for whites is 53.4% which may be compared to the rate of 50.6% for blacks.*
**Ten year survival rates are based on only a very small number of cases and must therefore be interpreted cautiously.*

TABLE 4
5-Year Relative Survival by Stage and By Treatment

	Localized		Regional		Distant	
	#	%	#	%	#	%
Hormone	257	61.9	69	56.1	306	20.5
Radiation	56	92.0	33	69.2	20	13.2
Hor/Radiation	30	99.3	26	58.6	44	40.2
Surgery	1039	77.7	133	55.5	116	23.9
Surgery/Hormone	904	66.0	185	62.6	209	26.4
Surgery/Radiation	65	73.2	24	77.2	27	36.1
Surg/Rad/Hormone	50	83.1	28	54.9	37	32.5

Figure 2



From Table 3, showing stage-specific relative survival by race, blacks experienced a generally poorer five year prognosis than whites even after adjusting for differences in age and stage of disease (five year adjusted relative survival: 50.6% vs. 57.3%, respectively). The 0.0% 10 year white and black survivals for *in situ* stage are explained by the fact that the numbers of patients (26 and 9) are small and that these patients died of causes other than prostate cancer. Older patients, especially those 80 or more years of age, had a poorer survival experience than younger patients.

Survival According to Treatment

Table 4 presents distribution and five year relative survival by stage and by treatment. By any modality, distant stage cases experienced consistently poorer survival than localized or regional cases. For example, patients with distant stage disease treated with hormones experienced a five year relative survival of 20.5% compared to 61.9% for localized cases and 56.1% for regional cases treated similarly. The 99.3% five year survival for localized stage disease treated by hormone and radiation is explained by the small number (30) of patients studied and the effectiveness of this therapy in that group. The 77.7% five year survival for localized stage disease for surgery is explained by the fact that orchiectomy and TUR (the most commonly employed surgical procedures) were effective in this group of patients.

The impact of stage at time of diagnosis is reinforced by Figure 3. As expected, patients with advanced disease had a substantially poorer prognosis than those with localized disease at both five and ten year intervals. Relative five year survivals are 67.9%, 57.2%, and 22.4% for localized, regional, and distant disease.

A 20% random sample of cases from 48 hospitals initially treated by surgery or radiation or a combination of these provides details of treatment modalities in Table 2. This sample was taken to determine the number of prostate cancer cases treated initially for cure. Surgery for cure was defined as radical prostatectomy with or without node dis-

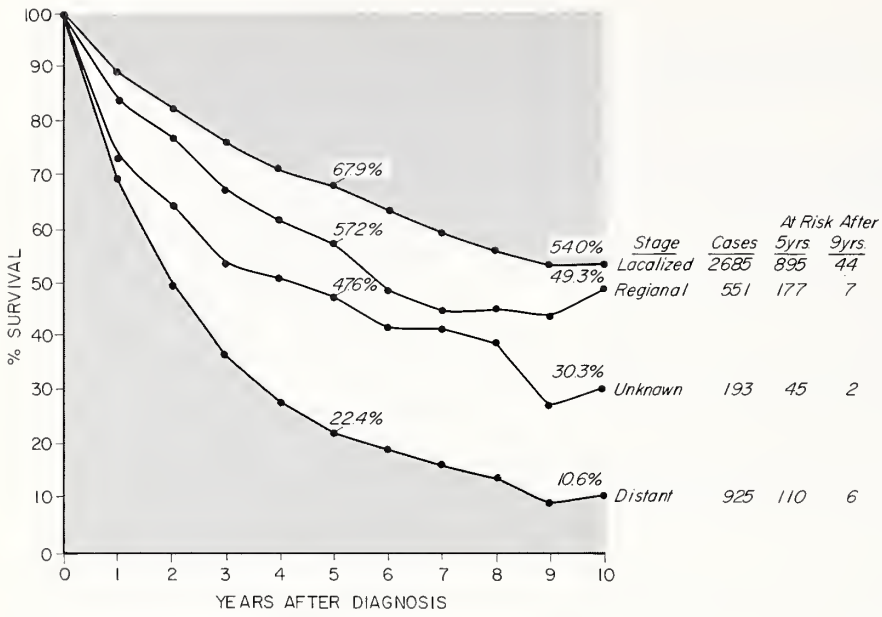


Figure 3

section, and radiation for cure was defined as 5,000 or more rads to the prostate and pelvis. Transurethral resection (TUR), constituting an estimated 74.1% of the surgical procedures, was most likely performed to relieve obstructive symptoms and not to eradicate prostatic malignancy. Surgery for cure was performed in 5.7% of these cases and curative radiotherapy was administered in 6.9% of cases.

Discussion

This study confirms national data demonstrating a large excess of prostate cancers in black men.[4,5] Although the excessively high proportion of black patients in the Illinois survey may result from an over representation of hospitals in Cook County which service a substantial segment of the total Illinois black population, there is no question but that local and statewide Illinois trends by race are in the same direction as in other surveyed states and areas. The severity of the problem is increased by the findings that the stage of the carcinoma was more advanced in blacks at time of diagnosis, possibly indicating a shortage of public health education programs in black communities, a lack of access to care or a disinclination to seek care by some black men, or a need for clinical surveillance programs in black populations.

However, these observations may not be taken to minimize incidences of prostate cancer in white men, which rank second only to those of lung cancer. The Illinois data again illustrate the well known steep rise in risk with advancing age, perhaps inflated in some degree from a low representation of white men resulting from the possible excess of black men in the sampled hospitals.

Staging distributions indicate that prostate cancers may not be served adequately by classification systems used for other cancers since the usual surgical procedure does not provide information on regional node involvement. Node dissections were performed in only 1% of cases. Grading was attempted in fewer than half of all cases.

A review of survival by stage and by race shows that survival tended to correlate inversely with stage and that blacks had a lower survival than whites. To evaluate more closely the effect of surgery or radiation for cure, a random sample revealed that only a small percentage of patients (5.7 and 6.9% respectively) were so treated. Advanced age of prostate cancer patients, concurrent diseases they may have, and difficulty in accurately staging these patients may have contributed to the low percentage of treatment for cure.

This study highlights several points: (1) prostate cancer appears more lethal in the black population and screening efforts might be directed at this high risk group; (2) staging criteria utilized for other tumors do not apply equally well to prostate cancer patients and perhaps different staging systems should be utilized for this malignancy; (3) improved grading criteria with prognostic potential should be developed and universally applied and (4) medical conditions permitting, curative attempts should be considered more frequently.

The message to be taken from this evaluation of 4,389 Illinois men with prostate cancer is that staging could be improved with bone scans, computerized tomographs or lymph node dissections. Treatment methods could be improved by employing curative radiotherapy or radical surgery for those patients with localized disease and an acceptable medical status. ◀

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Each of the authors is a member of the Cancer Incidence and End Results Committee of the American Cancer Society, Illinois Division.

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A Guide in Evaluating, Reporting and Treating Low Back Syndromes

By Eugene J. Rogers, M.D. and Robert J. Rogers, M.D./ North Chicago

This paper outlines an approach in evaluating patients with low back syndromes. Forms are suggested to render more informative reports for those in need of medical data. (Copies of the forms are available from the authors.) Physicians treating more severely impaired patients may use the guidelines toward a more comprehensive rehabilitative approach.

Head, back and shoulder aches are the most frequent sources for pain and disability secondary to injury, stress and strain.[1] Back and neck pains occur in 16% of the population for at least one month per year.[2] The Bureau of Labor Statistics recently reported that approximately one million workers sustained back injuries in 1980.[3] These back problems occur predominantly in the work ages of 30-40. Inflammatory and traumatic etiologies may occur in the prior years. Those over 50 years of age may have multiple myeloma, malignancy or metastasis, Paget's, spinal stenosis, osteoarthritis and osteoporosis, particularly in females.

The extensive occurrence of this back pain syndrome warrants a review of appropriate diagnostic work-ups and assistance in developing more definitive objective reports. In conjunction with earlier referrals for rehabilitation programs, these activities may help to contain the ever increasing costs of medical care.

The Work-Up

Physicians may use office personnel and patients in the accumulation of an adequate history. (Table 1 and Figure 1) This should include information regarding onset, palliation, quality, radiation, severity and time.

Onset: The activities prior to the onset of this syndrome may assist in localization of the involvement. A compressive force, such as lifting, may involve the vertebrae, the pedicle or discs. A shearing force may involve the articular capsule, a disc, the apopheseal joints with possible arthritic process, listhesis of L_5 on S_1 at 45° angle, or ligamentous tears. Tensile stresses may involve ligaments (sprain) or muscles (strains) and those relating to repetitive over-utilization frequently involve muscle tissue only.

Palliation with heat, rest, medicines, progression and experiences with previous episodes should be noted. *Quality of pain* (burning, sharp, ache) and sensation (pins & needles, tingling, numbness) should be considered. Also reportable are radiation of pain and its severity (and its effects on activities, including toilet, dressing, ambulation, transference, sexual activities). A consideration of time includes relationships to time of day and some activities.

Pain, disability and psychosocial behavior are interrelated in regard to stressful situations. The course and prognosis warrant an exploration of all three factors in the history and physical data base. The questionnaire and the physical findings contain information in all three spheres.

The physical data describe findings on inspection, palpation, percussion, and auscultation of the femoral vessels. The neurologic data should also include measurable data as to limitations in range of motion, circumference, Schober's flexibility test, leg lengths, muscle strength, temperature and rectal examination.

The laboratory data, in addition to the usual blood and urine analysis, frequently include an AP flat X-ray plate. These demonstrate

only changes in alignment, joints, continuity, densities of bone and soft tissues. Repeat X-rays of similar type are superfluous, add no additional information, may be deleterious because of additional radiation exposure and represent unnecessary costs. The sacroiliac joint and apophyseal joint pain may represent early manifestations of ankylosing spondylitis with coincidental onset with minor trauma. If neurologic deficits are present, the conventional flat plate should be supplemented by tumography to properly demonstrate soft tissue encroachments and compression syndromes. Electromyography may be helpful 10 days after injury, particularly in the paravertebral muscles. The paravertebral muscles have the shortest nerve paths and thus may show abnormalities early in axonal damage or myelin sheath involvement. The more distal nerves to the extremities may be abnormal later. Part of the evaluation includes the evoked F and H reflex responses to electrical stimuli exhibiting delays in transmission of nerve impulses through the spinal loop.

Some of the differential diagnoses in low back syndromes may include: myofascial trigger points; arthritides, bursitis, tendonitis, peritrochanteric syndrome; sprains, strains; pelvic disease; inflammatory diseases; osteoporosis; neurologic evidence of disc compression, neuritis, meralgia paresthetica, spinal stenosis, pyriformis syndrome, wallet syndrome; ankylosing spondylitis; osseous diseases as tumors, metastatic lesions and Pagets and psychosomatic manifestations. (Table 2)

Myelography occasionally undertaken in cases with neurologic deficits may identify the sites, levels and extent of involvement. It generally precedes surgical intervention.

Patients presenting with low back syndrome are difficult to evaluate. Confirmatory testing may be required when the physical findings are incompatible with the multiplicity and severity of complaints. A straight leg raising sign, when posi-

Table 1
Questionnaire

Name _____ Age _____ Employer _____
Address _____ Address _____
Telephone _____ Occupation _____
Duration of present employment _____ Ins. carrier _____
Previous treating physician _____ Carr. address _____
Address _____
Previous surgeries _____
Present onset date _____ Previous onset dates _____
Duration _____
Activities: Lifting, Pushing, Bending, Twisting, Pulling, Other _____
Immediate _____ Over hours _____ Over days _____ Progressing _____ Same _____
Severity of Pain (1 = Mild, 5 = Severe) _____
Pain interferes with: Work ____ Dressing ____ Toilet ____ Hygiene ____ Ambulation ____
Transfer ____ Sleep ____ Sexual activity ____ Appetite ____
Emotional reactions: Tense ____ Nervous ____ Irritable ____ Depressed ____ Fam. probs. ____
Other Symptoms _____
(See Figure 1)

Pain Improved:	Present	Previous
Heat		
Standing		
Walking		
Medicine		
Pain Worse:	Present	Previous
Walking		
Coughing		
Bowel movement		
Urination		
Inclement weather		
Standing		
Resting		
Have Problems With:	Medications Now	
Allergies	_____	
Heart	_____	
Kidneys	_____	
Gynecologic	_____	
Bowels	_____	
Urination	_____	
Legs	_____	

Prior Hospitalizations:
For _____ Dates _____
_____ _____

Table 2

Physical Findings for Low Back Patients

Height _____ Weight _____ Change in wt. _____ BP _____ P _____ Resp _____ Temp _____

Appearance & demeanor: _____

Emotion reaction: Depressed _____ Irritable _____ Uncooperative _____ Somatic Preoccupation _____
Hyperhidrosis _____

Gait

Stride: Symmetric _____ Rhythmic _____

Motion: Arms _____ Pelvis rotation _____ Tilt _____

Shoulders _____ Knees _____

Trunk _____ Ankles _____

Muscle Strength

Lordodic Abdominal _____ Hip contracture _____

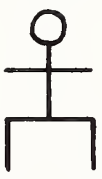
Push off _____ Toe & ankle lift _____

Weight Bearing

Duration _____ Pain _____

Posture

Level Shoulders
Pelvis
Scoliosis
Lordosis
Kyposis
Plumbline

Rt  Lt

Back  Front

Code

0 = Normal
↓ = Restriction or decrease
↑ = Increase
— = Alignment

Measurements	Right	Left
Leg length	_____	_____
Chest expansion (nipple level)	_____	_____
Circumference: above knee	_____	_____
(5″ above & Knee	_____	_____
below patella) Below Knee	_____	_____
Fingertip to knee (lat. tilt)	_____	_____
Pulses		
Femoral	_____	_____
Popliteal	_____	_____
Post. tibial	_____	_____
Dorsalis pedis	_____	_____
Strengths		
Hip flexion ($L_{2,3}$)	_____	_____
extension ($L_{4,5}$)	_____	_____
Knee flexion (L_5S_1)	_____	_____
extension (L_3,L_4)	_____	_____
Ankle dorsiflexion (L_5S_1)	_____	_____
plantarflexion (S_1S_2)	_____	_____

Range of Motion

Neck flexion

Trunk flexion _____ Extension _____ Rotation: R _____ L _____

Fingertip to floor _____ Cm Lat. deviation: R _____ L _____

Schober's (Ver. L_5+10cm) then Flex trunk _____ Cm Trunk hyperextension _____

	Right	Left
SLR --- Supine:	_____	_____
Sitting:	_____	_____
Heel to Knee (Faber)	_____	_____
Knee on Chest	_____	_____

Reflexes	Right	Left
Patella (Femoral $L_{2,3,4}$)	_____	_____
Gluteal (Superficial $L_5S_{1,2}$)	_____	_____
Achilles (Tibial S_{12})	_____	_____

(See Figure 2)

Pain Tolerance
Pressure over stylomastoid area
Pupil size with pain response
Apparent emotional reaction

Rectal_____ Sphincter tone _____

Summary—Positive findings _____

Working Diagnosis

	Right	Left
1. No Objective Findings		
2. Muscle Strain	_____	_____
3. Sprain SI	_____	_____
LS	_____	_____
4. Contusion	_____	_____
5. Disc level, Pyriformis syndr.	_____	_____
6. Spinal stenosis	_____	_____
7. Tumor	_____	_____
8. Osteoporosis	_____	_____
9. Inflammatory Disease—Arthritis, Bursitis, Peritronchanteric syndr.	_____	_____
10. Myofascial pain syndrome	_____	_____

Additional Work-up
Lab: SLA, CBC, UA, SMA20, SED, HLA27, ANF, RF, EMG & N. Conduction
CAT scan
Psychologic evaluation
Myelogram
Thermography

Work Recommendations
Resume regular work _____ Date _____
Resume work with restrictions in bending, lifting, pushing, standing:

No work (weeks): _____

Refer to Dr. _____ DVR _____ Social work _____

Treatments
Heel lift RT _____ LT _____
Back support _____ Rest _____ Hosp. _____
Medications
Muscle relaxant _____
Salicylates _____
Non-steroid anti-inflammatory _____
Phenylpropionic acid derivative _____
Narcotic or derivative _____
Antidepressant _____
Chymopapaine _____

Rehabilitation
Physical therapy _____
Heat _____
Cold _____
Traction _____
U.S. _____
Exercise _____
TNS _____
Biofeedback _____
Behavior modification _____
Vocational counselling _____
Occupational therapy _____
Instructions in body mechanics _____
Next visit: _____ Signature _____
Date _____

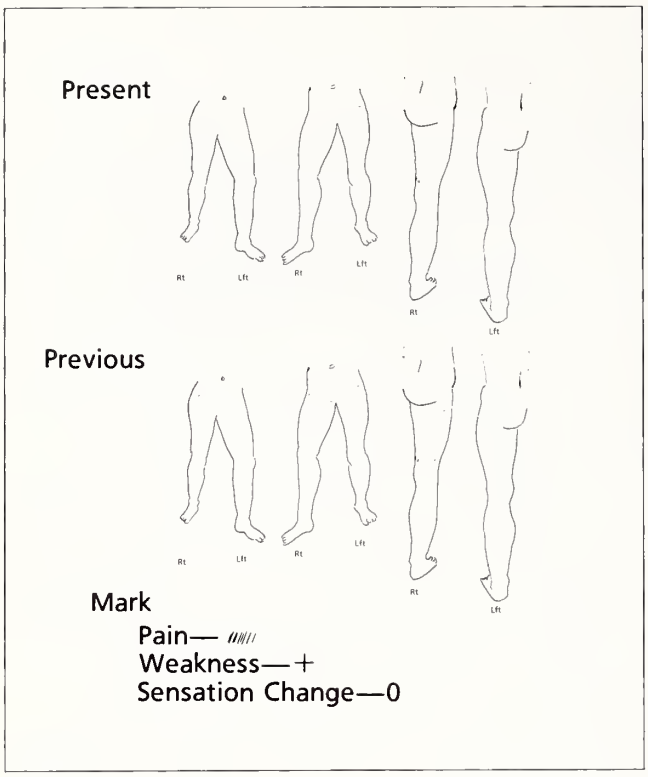


Figure 1

Patient to mark areas of pain, weakness and sensory changes.

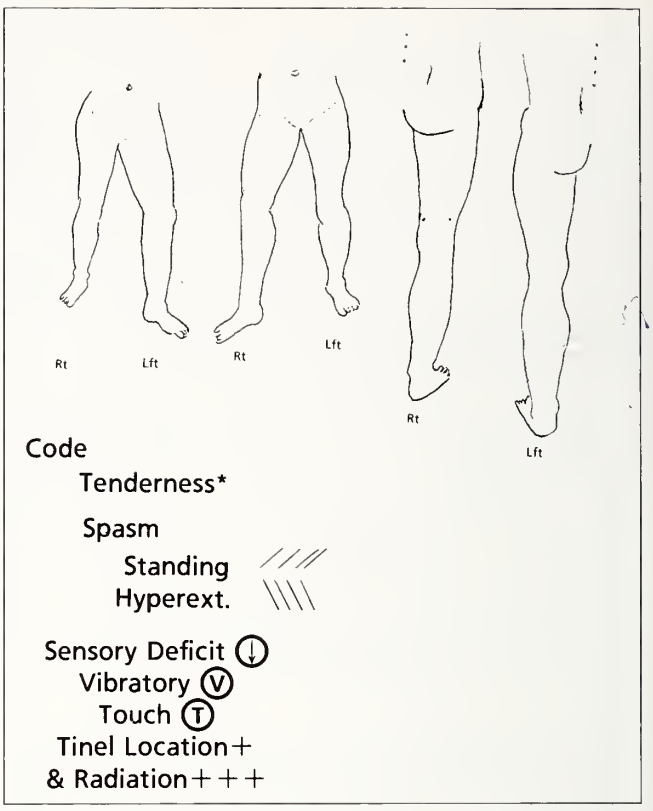


Figure 2

Physician to mark areas as indicated in the code above.

tive in the supine position, should also be present when sitting in a chair. In nerve entrapment or compression, pain may be aggravated with neck flexion. Actively raising one leg in the supine position normally results in a downward pressure on the contralateral heel. Involuntary muscle spasm palpated in the standing posture should persist on hyperextension of the trunk.

Summary

Low back syndromes represent a major entity of pain, disability and cost. Physicians are increasingly challenged in evaluating these patients, to ameliorate the pain, the disability, and to reduce the mounting costs to employees, employers and carriers. An outline is offered to enhance diagnoses, improve and facilitate medical reports, hopefully improve care and reduce costs.

The activity at time of onset may indicate the structural areas of involvement. Associated problems with functional impairments can assist in delineating pain tolerance. Neurologic deficits preclude the value of simple X-rays and warrant tumographic evaluations and electrodiagnostic studies.

Most low back syndromes are self-limiting with satisfactory responses to conservative management. The more chronic cases warrant a comprehensive rehabilitative approach prior to surgical laminectomies. ◀

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A Brief Review

Cephalosporin Induced Coagulopathies

By Ruth Andrea Seeler, M.D. and John Reitan, Pharm. D./Chicago

It is indeed ironic that the cephalosporins which have been widely developed and promoted as broad-spectrum, safe antimicrobials, are now recognized to induce severe, life-threatening and in some cases a fatal coagulopathy.[1-13] The three cephalosporins primarily responsible for this mini epidemic of hemorrhage are: cefamandole nafate,[1-3] moxalactam disodium[4-10] and cefoperazone sodium.[11]

This is not a rare phenomenon. The bibliography spans only two years and includes data on 50 patients with cephalosporin induced coagulopathy and moxalactam thrombopathia. Each of these antibiotics has a N-methylthiotetrazole side chain which is thought to be responsible for inducing the Vitamin K deficient coagulopathy (hypoprothrombinemia) as well as the antabuse type of reaction seen in some of these patients.[12,13]

Vitamin K homeostasis depends upon three variables: dietary intake of Vitamin K, endogenous synthesis of Vitamin K_2 by bacteria of the large bowel and adequate time and bile to facilitate absorption of the fat soluble vitamin. Most adults do not become Vitamin K deficient even when oral alimentation is discontinued because the large bowel flora synthesis of Vitamin K_2 is adequate in the presence of normal gastrointestinal function. The antibiotics under discussion are excreted into the bile and therefore alter the flora of the gastrointestinal tract. It is proposed that the Vitamin K producing bacteria are therefore significantly reduced.[3]

Some authors have also postulated that the N-methylthiotetrazole side chain may affect the calcium binding site either directly or indirectly via the enzymes which attach the gamma carboxyglutamic acid (calcium binding site) to the precursor coagulation molecule.[12,15] Most authors, however, are favoring destruction of the endogenous Vitamin K_2 producing bacteria as the primary etiology coupled with no oral intake.

Clinical Aspects

The Vitamin K deficient coagulopathy may be quite severe, with prothrombin times (PT) regularly prolonged to 20-30 seconds with a control value of 10-13 seconds. PT's in excess of 75-150 seconds have been reported.[2,4,11] Patients with this severe a coagulation disturbance have suffered clinically significant or fatal hemorrhage.

The hypoprothrombinemia due to the cephalosporins initially appeared limited to patients with renal failure, who were old and debilitated or who had a history of liver disease or excessive alcohol intake.[2,5,11] As more experience and familiarity with this complication developed, it became obvious that severe hypoprothrombinemia can occur in previously healthy nondebilitated individuals. Most patients with the coagulopathy have been postoperative with complicated courses. However medical patients are now being reported with hemorrhage.[1,4]

The authors reviewed the chart of a child from another institution who was admitted with encephalopathy and had initially normal coagulation studies. The child needed a respirator and was placed on cefamandole because of a fever. On the fourth day of cefamandole therapy, the PT and PTT were markedly prolonged (see Table 1). These abnormal results were confirmed immediately and the child given Vitamin K_1. Eight hours after the Vitamin K_1 the PT and PTT were again normal. The child had no abnormalities of the gastrointestinal or biliary system and had no diarrhea. Subsequently, despite the continued administration of cefa-

Table 1
Cefamandole Induced
Vitamin K Deficiency

	PT (sec.)	PTT (sec.)
Adm. in coma	12.9	26
Fourth day	19.6	45.9
Fourth day rechecked	20.2	47.7
Vitamin K_1 Given		
Eight hr $\bar{p}$ K_1	12.9	31.5

mandole the PT remained normal but in the interval the patient had been started on nasogastric feedings.

The onset of the coagulation disturbance is usually within the first week of therapy, usually about three days, but an occasional patient did not develop the hypoprothrombinemia until the twelfth day of antiobiotic therapy.[1,4,11] As one reads the various case reports, it is quite clear that a rapid reversal of the coagulation disturbance follows Vitamin K administration. This would suggest pure Vitamin K deficiency rather than a competitive inhibition of N-methylthiotetrazole with the enzyme needed to attach the calcium binding site. The current recommendations from the 1983 PDR and the pharmaceutical companies are that patients receiving moxalactam, cefamandole or cefoperazone also receive Vitamin K. The concurrent weekly administration of 10 mg. of Vitamin K_1 will prevent the hypoprothrombinemia but cannot be counted on to completely prevent a hemorrhagic diathesis in patients receiving moxalactam.

Moxalactam Thrombopathia

In addition to the Vitamin K deficiency, moxalactam may induce abnormalities of platelet aggregation accompanied by a marked prolongation of the patient's bleeding time.[7-10] Bleeding times in excess of 25-30 minutes (nl < 8 min) have been reported. Concurrent platelet aggregation studies showed a thrombopathia pattern with both collagen and ADP. A thrombopathia pattern is the absence of the second wave of platelet aggregation.

Platelet aggregation studies and the bleeding time returned to normal approximately three days after moxalactam was discontinued.[7,11] This platelet dysfunction is very similar to that previously reported for carbenicillin. It is thought to be the carbenicillin-like alpha carboxy substitution which gives moxalactam its antipseudomonal activity.[7]

As is the case with carbenicillin, the platelet dysfunction is dose related. Patients in renal failure would be expected to exhibit the most severe moxalactam thrombopathia. Also, moxalactam is excreted into the bile and any hepatic or biliary disease would also lead to high blood levels and a more profound bleeding disturbance.

Clinically significant bleeding occurs in 2.5-3% of patients receiving moxalactam for a four-day period.[14] According to one review, in a one year period, the FDA received reports of 81 patients with moxalactam coagulopathy in whom the overt bleeding was severe in 32 and included 13 deaths.[12] The clinician must remember that patients receiving moxalactam and Vitamin K can still develop a severe hemorrhagic diathesis due to the thrombopathia.[10]

Platelet concentrate transfusion would not be expected to reverse thrombopathia because it is the direct effect of the drug on the platelets. Transfused platelets would develop the thrombopathia after interaction with the drug in the patient's circulation. Platelet concentrates may have a transient effect but the kinetics of the moxalactam thrombopathia have not been published.

Immune Mediated Thrombocytopenia

All cephalosporins and penicillins may induce an immune mediated thrombocytopenia in susceptible persons.[13] This phenomenon is rather uncommon when compared to the Vitamin K deficiency and the thrombopathia. The clinician must bear in mind that a decreased platelet count in these sick patients may be a combination of suppressed production due to sepsis, DIC and/or drug mediated immune destruction. More than one mechanism may be operative in any given patient. When the thrombocytopenia is due to an immune mediated mechanism, transfusion of platelet concentrates will not increase the platelet count.

Conclusion

Patients receiving cefamandole, moxalactam or cefoperazone may develop a Vitamin K deficient coagulopathy. This is particularly true in the patients who are not receiving oral alimentation. Old debilitated patients with hepatic, gastrointestinal or renal disease are also particularly at risk. The concurrent administration of Vitamin K_1, 10 mg. weekly for an adult, should be sufficient to prevent the hypoprothrombinemia. In pediatrics, infants should receive 1-2mgs. and older children 5mgs. weekly.

Like carbenicillin, moxalactam may also induce platelet dysfunction which may occur even in the absence of the Vitamin K coagulopathy. Lastly, all three drugs may cause an immune mediated thrombocytopenia.

Any patient receiving antibiotics who develops a hemorrhagic diathesis should be fully investigated with a platelet count, PT, PTT, and bleeding time. Appropriate therapy includes Vitamin K when the problem is a Vitamin K deficiency. Change to another antibiotic should be strongly considered in patients with either thrombopathia or thrombocytopenia. ◀

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Max Thorek

(Continued from page 331)

ministered to and made friends with celebrities such as Bill Cody, the star of Buffalo Bill's Wild West Show, the magician, Harry Houdini, and the glamorous actress, Lily Langtry.

Thorek was, for a brief period in his career, involved with an odd episode in the history of medicine. In the early decades of the twentieth century, the scientific community and lay public as well were fascinated with the prospect of restoration of youth by means of surgery. Thorek championed this cause. He befriended some of the men who prompted "gland grafting"—the transplantation of the gonads of a young animal to an animal or person who demonstrated unwanted signs of aging. Thorek's own research efforts were carried out in a laboratory referred to, because of its profusion of animal inhabitants, as the "Irving Park Zoo." Eventually, Thorek became disenchanted with most attempts at rejuvenation but, even as late as 1943, he maintained that such procedures, when appropriately employed, could benefit select patients.[1]

Thorek's hobbies brought him recognition, as did his professional endeavors. He enjoyed an international reputation as a photographer, exhibiting his work in this country and abroad. Today, a selection of his photographic prints belong to the permanent collection of the Smithsonian Institute in Washington, D.C. He organized the Photographic Society of America and also wrote two popular books on the subject: Creative Camera Art and Camera Art as a Means of Self-Expression.

Thorek is recognized today for making prodigious contributions to the medical literature. His work consists of articles on a wide range of subjects: he wrote about abdominal surgery, medical history, problems in orthopedics, endocrinology, gynecology, and neurosurgery. Always sensitive to the feelings of his patients, he addressed deformities requiring reconstruction. He enthusiastically defended the value of cosmetic surgery long before it was generally acceptable to do so. His books include Surgical Errors and Safeguards, (1933), Thorek's Illustrated Surgical Technique, (1935), and his lively autobiography, A Surgeon's World, (1933).[3]

Thorek enjoyed the recognition of the professional community for his achievements. He served as active or honorary member of many organizations, but perhaps the appointment dearest to him was that of Secretary General of the International College of Surgeons, a society which he was instrumental in establishing in 1935. He also served as editor-in-chief for the Journal of the College. When Thorek died of a heart attack at the age of eighty in 1960, he was eulogized in that journal as a friend, an inspired surgeon, and a great but humble man whose life was conducted according to the high standards of his profession.[4]

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Clinical Experience

Eustachian Tube Bypass

By Abraham Lapidot, M.D. and
Alan Rubenstein, M.D., Springfield

This report is a follow up of previous publications.[1-3] The research was first presented at the Seventh Shambaugh-Shea International Workshop on Otology, March 1-4, 1984, Chicago; and also was presented at the Missouri State Medical Assn. 126th Annual Convention, March 29-April 1, 1984, St. Louis, Missouri.

A patient, aged 43, suffered from right chronic ear disease most of his life. Extensive cholesteatoma affected his right middle ear. Three otologic procedures were necessary to eradicate disease. Cholesteatoma affected the region of the eustachian tube opening in the middle ear and eustachian tube disease and obliteration was clearly demonstrated. Cochlear function was intact though conductive loss was in the region of 60-70DB in the speech range. It was the consensus of three local otolaryngologists that a eustachian tube bypass was indicated and this was performed. The technique was as outlined in previous publication[2] and a pre-formed total eustachian replacement prosthesis (TERP) was inserted. The operative time for the middle ear surgery prior to insertion of the prosthesis was approximately 75 minutes. No attempt was made to restore conduction since further exploratory surgery would be necessary in the future. The remaining malleus was removed.

Results

Recovery was uneventful excepting transient postoperative drainage which resolved with local and oral medications. Since the pharyngeal end of the prosthesis was flanged and flush with the surface of the mucous membrane of the superior constrictor muscle, an over-abundance of air ventilated the middle ear with each swallow as anticipated. The surgeons planned to allow ingrowth of the mucous membrane into the lumen of the flange over 50% of the circumference. The remaining margin of mucous membrane was cauterized so that the flanged end would always be in view. The middle ear could readily be suctioned through the prosthesis. After five months with a healed ear, ventilated via the eustachian tube bypass, it was the consensus of the group that ossicular reconstruction should be performed. Under local anesthesia, homograft ossicles were utilized for conduction reconstruction. The pertinent observation was that bubbles of air entered the middle ear as the patient was asked to swallow. Postoperatively the patient stated "I hear at least 75% better than I heard before," and the audiogram showed 40DB at the 4000cps. With the ear stable, the visible margin of the prosthesis flange was trimmed to allow epithelial growth along the remaining 50% of the prosthetic end, so as to achieve an opening fully epithelialised and resembling the external os of the uterus.

Following this maneuver, further antibiotics were necessary to control recurrent drainage. During this time, ear drops that were prescribed for the patient were felt in the oropharynx and ventilation of the middle ear was clearly experienced. At 13 months after the bypass procedure, the ear was stable and dry, and hearing was maintained. In view of the "much learned," experience a further series of patients will be operated upon with minor modifications.

Discussion

In a city with a population of 100,000 people, approximately 20 ear vent tubes are placed in children weekly. Far fewer adults require vent tubes but the number is gradually increasing for reasons not definitely established. A significant percentage of this patient population will experience hearing loss and eustachian tube insufficiency requiring periodic vent tube insertions. This will limit the patient's lifestyle for the constant fear of "getting the ear moist." It is hoped that the eustachian tube bypass procedure will eliminate this. Access to the middle ear remains a minor, readily achievable office procedure, when a eustachian bypass is in place.

Summary

Chronic eustachian tube insufficiency continues to be lacking in permanent control. The use of tubes is the most functional method at the present time of middle ear ventilation. This report relates to clinical experience of middle ear ventilation via an eustachian tube bypass. A specifically designed silastic tube is lodged behind the ear drum into an inverted V-shaped isthmus created anteriorly and inferiorly in the medial wall of the middle ear. The tube courses behind the neck of the mandible through the muscles of mastication and emerges in the oropharynx through the superior constrictor, just short of flush with the surface of the mucous membrane. The slit-like opening of the bypass is in the anterior oropharynx. It is covered by mucous membrane and resembles the external os of the uterus. The TERP (total ossicular replacement prosthesis) is entirely submerged in body tissues. Access to the middle ear is a minor, readily achievable office procedure if required.

The longest patient in the series at this writing is one year. The ear is ventilated via the bypass, which is very well tolerated and hearing is improved.

Conclusion

It would appear that ventilation of the middle ear as normally achieved in the nasopharynx is possible via the oropharynx. It would appear that the action of the superior constrictor muscle can effectively ventilate the middle ear in the oropharynx.

Acknowledgement

We acknowledge the generous support and cooperation of Dr. H.R. Konrad.

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Effect of Preseason Conditioning

High School Football Knee Injuries

By Bernard R. Cahill, M.D., Edward H. Griffith, Ph.D., Jeff Sunderlin, M.S., A.T.C., Tim Madden, M.S., A.T.C. and Arthur Weltman, Ph.D./Peoria

In a 1978 paper, Cahill and Griffith[1] reported that a closely supervised, high quality, preseason conditioning program (PSC) resulted in a significant reduction in the incidence and severity of high school football knee injuries. The present paper reports that a decrease in supervision of the quality of PSC does not reduce the benefits obtained from PSC.

Subjects in the present study were varsity football players in the Midstate Eight Conference in Peoria, Illinois. Three groups of subjects were compared in the present study. The no conditioning group (NC) refers to athletes evaluated during the years 1969 to 1972. The closely supervised PSC group (C1) refers to the years 1973 to 1976 and the less supervised PSC group (C2) refers to the years 1977 to 1980. Data of the NC and C1 groups have been reported in detail elsewhere.[1] The same methods that were utilized previously[1] were used in the present study to assure that the senior author would have accessability to all reportable knee injuries.

Pre-Season Conditioning (PSC)

The Illinois High School Association has mandated that PSC be a voluntary program for the individual athlete. PSC begins six weeks before the official beginning date of football as established by the IHSA. Teams met 80 minutes per session, three evenings per week. The coaches were allowed to schedule a maximum of 18 team sessions but most teams met 12-14 times. No drills, plays, football, or "team meetings" were permitted by the IHSA at these preseason conditioning sessions.

The preseason conditioning program emphasized total body conditioning through cardiovascular stressing, acclimatization to heat, weight training, flexibility drills, agility exercises, and is similar to that programs of Henderson and Erickson[2] and O'Donoghue.[3] We did not condition only the lower extremities. (Details of PSC may be obtained by writing the senior author.)

The major difference between the C1 and C2 groups in the present study was the degree of supervision of PSC in C2. There was less supervision of PSC quality in C2 by the members of the sports medicine staff. The C2 coaches exercised discretion in modifying the described PSC programs. Physical contact by the athletes did not occur, but the C2 group program reflected less balance between time spent on flexibility, agility, cardiopulmonary conditioning and strength training when compared to C1. There was little disparity between the two groups in length of PSC and the time spent per session.

A number of environmental changes also occurred during this study. While the NC and C1 groups had a stable coaching cadre, there were significant coaching changes in the C2 group. There was not a significant change in scheduling, number of games played, or level of competition between groups. In addition, for C2 the ease of injury data acquisition was enhanced by the addition of a full-time trainer who was responsible for four high schools, and close injury surveillance of the remaining four schools by outside trainers. A football injury clinic for area athletes was instituted in 1978, and provided diagnostic, treatment, and rehabilitative services.

An identical injury definition as described previously was used for all groups.[1] A knee injury was defined as one severe enough to

Table 1
Breakdown of Knee Injuries by Year (1969-1980) And Condition (NC, C1, C2)

Group	Year	Number Players	Knee Injuries	Number Operations	Operations per 1000 Athletes	Injuries per 1000 Athletes
NC	1969	318	24	6		
	1970	312	16	4		
	1971	307	22	4	15	68
	1972	317	23	5		
Totals		1,254	85	19		
C1	1973	298	18	1		
	1974	277	16	4		
	1975	350	9	1	5	41
	1976	302	7	1		
Totals		1,227	50	7		
C2	1977	335	17	1		
	1978	338	5	0		
	1979	322	15	0	2	39
	1980	313	14	2		
Totals		1,308	41	3		
Totals		3,789	186	29		

NC = No preseason conditioning
C1 = Closely supervised preseason conditioning
C2 = Less supervised preseason conditioning

cause the athlete to miss, or not fully participate in, two consecutive practice sessions, or a practice session and a game. All of the injured athletes in the present study were seen and treated by the senior author.

Results

During a 12 year period (1969-1980), 3,789 varsity football players sustained 186 knee injuries. Of these, 29 required surgery (Table 1). A comparison of the injury rate per 1,000 athletes shows a rate of 68 for the NC athletes and approximately 40 for the C1 and C2 groups. The operative rate per 1,000 players was 15.2 for the NC group, 5.7 for the C1 group and 2.3 for the C2 group. The seriousness of knee injuries sustained is presented in Table 2. These data were determined from three categories of the injury form (hospitalization, participation after injury, and days lost). Athletes requiring hospitalization in this category do not include those admitted to the hospital for surgery. The number of athletes requiring hospitalization for conservative treatment of their knee injuries decreased markedly in the C1 and C2 groups as compared to NC ($p < .05$). Those athletes who were not allowed to participate after their injury but were not hospitalized did not change significantly during the 12 year period. For those athletes who were allowed to participate, days lost after sustaining a knee injury showed a strong trend to fewer days lost in the C1 and C2 groups as compared to the NC group. PSC was also effective in reducing the number of early season knee injuries (from the beginning of practice through the third game). The early season knee injuries were reduced by 67% in the C1 and C2 groups as compared to the NC group.

Discussion

The present study supports the previous finding of Cahill and Griffith[1] that preseason conditioning results in a decrease in knee injuries. These data also indicate that the reduction of direct supervision of the PSC programs did not reduce the benefits of PSC (Table 1 and 2).

The effectiveness of PSC in the C2 (less supervision) group was high in spite of several evironmental changes that occurred during the C2 years. These changes could have been construed to militate against a beneficial effect of PSC. First, PSC was not as closely supervised for the C2 group. Secondly, four new coaches (out of a total of eight schools) not familiar with the benefits of PSC began during 1977-1978 season. Finally, the increased participation by athletic trainers in the C2 group could be assumed to improve injury awareness and injury reports, potentially accounting for more reported injuries in the C2 group. In spite of these environmental changes, the total number of knee injuries remained reduced in the C2 group. The severity of those injuries that did occur in C1 and C2 groups as compared to the NC group were less as measured by the decreased number of operated knees, fewer days lost after injury and fewer hospitalized athletes. Injuries not allowing participation, but not requiring hospitalization, remained the same throughout the study. This may be a result of increased trainer surveillance of injured athletes and a tendency to withhold players from competition

Table 2
Comparison of Severity of Knee Injuries Among Groups

	No. of injuries			
	NC	C1	C2	Total
Injuries requiring hospitalization	16	4	3	23
Injuries not allowing participation, but not requiring hospitalization	34	22	30	86
Injuries allowing partial participation	28	12	9	49
Injuries allowing active participation	9	6	5	20
Number of days of participation lost due to injury				
Missing 0-5	31	31	21	83
Missing 6-25	34	9	17	60
Missing more than 25	20	10	9	39

NC = No preseason conditioning
C1 = Closely supervised preseason conditioning
C2 = Less supervised preseason conditioning

and rehabilitate them without hospitalization.

Although the number of knee injuries was decreased significantly from the NC group to the C1 and C2 groups, the percent of knee injuries occurring in games as opposed to scrimmages and drills in practice remained constant throughout the 12 years of the study. Between 40 and 44% of reported knee injuries occurred during games while 54 to 55% of reported knee injuries occurred during scrimmage and drills in practice.

Summary

A 12 year study comparing high school football players who were not involved in preseason conditioning and those players who were involved in closely and less supervised preseason conditioning programs, has revealed that the number and severity of knee injuries that do occur may be significantly reduced by total body preseason conditioning. Close supervision of preseason conditioning by members of a sports medicine staff does not appear to be necessary, provided that coaches receive adequate instruction.

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Editor's Note

The increased incidence of sports-related injuries has paralleled the fitness boom and the tremendous rise in participation in athletic competition. Treatment of such injuries has become part of the practice of a rapidly-growing number of physicians. At the same time, school boards and others responsible for athletic programs are exhibiting heightened interest in injury prevention and treatment.

This is the fourth in a series of articles prepared under the direction of the ISMS Sports Medicine Committee that will focus upon clinical sports medicine topics and related issues. The series is intended to broaden clinical knowledge, aid the physician in educating patients on preventive measures and, hopefully, stimulate physician involvement in activities designed to protect the health of young athletes. The Committee welcomes your comments and suggestions.

Arthur Weltman, PhD., is director of research, education and exercise physiology, Center for Sports Medicine and Health Fitness, St. Francis Medical Center, Peoria. A former associate professor, department of physical education and recreation, University of Colorado, Dr. Weltman now conducts an externship program for University of Illinois medical students.

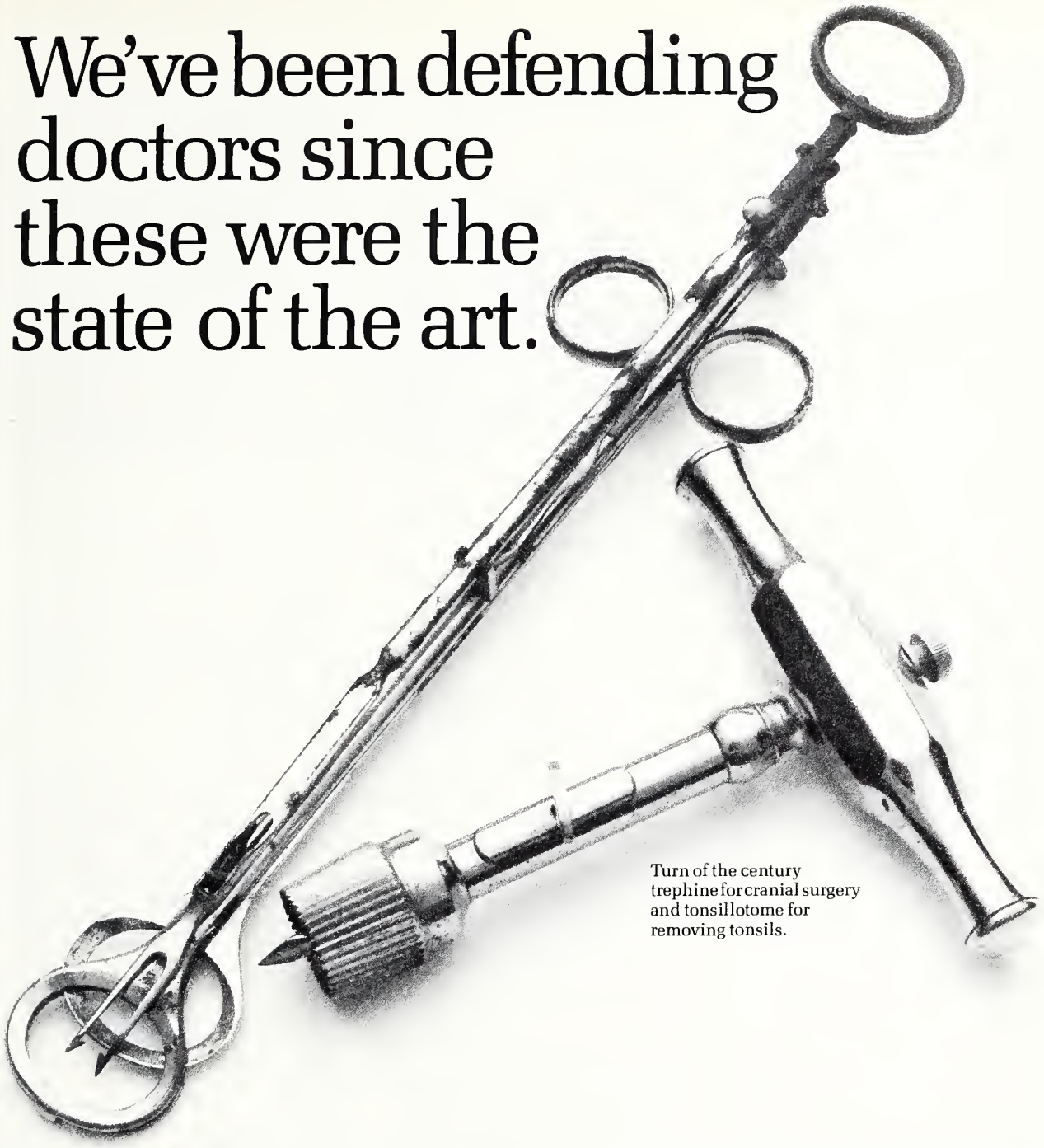
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(Continued from page 328)

Diagnosis: Aphthous Ulcers, Crohn's Disease.

All of these patients have small collections of barium, aphthous ulcers, of the gastrointestinal tract. All of the choices can mimic or present with aphthous ulcerations.

Normal Lymphofollicular Pattern

Diffuse fine nodularity of the colon and ileum is a frequent occurrence in normal children. The radiographic appearance is that of numerous, evenly distributed, nodular filling defects which are less than 2mm in size and tend to be limited to short segments of the bowel.[1] Barium may occasionally accumulate in central umbilications simulating aphthous ulcers. Histologically, the filling defects represent mucosal elevation due to underlying lymphoid follicles. In the adult colon, lymphoid follicles are usually fewer in number in comparison to children,[2] but the normal follicular pattern is not rare in the adult population. In a study of 100 consecutive double-contrast barium enemas, Kelvin, *et al*,[2] demonstrated this pattern in 13% of adults age 20-79. The areas primarily involved included the ascending colon and hepatic flexure with involvement of the small bowel in 20% of those patients who underwent a small bowel follow-through.

Clearly, the radiographic patterns in Figures 1-3 are not consistent with a normal lymphoid follicular pattern.

Ischemia

It is well known that large focal ulcerations can occur secondary to ischemia of the bowel.[3] It is noteworthy that oral contraceptives have been implicated as a cause of aphthous ulcers in the colon.[4] Oral contraceptives are well known to increase the platelet count, decrease antithrombin III levels, promote thromboplastin generation, and decrease partial thromboplastin time which has led to the postulation of the "hypercoagulation state theory."[5] Decreased venous return has also brought into question a "low-flow state."[3] Both hypothesis help account for bowel ischemia as the etiology of aphthous ulcers in these patients.

Ischemia could cause large focal colonic ulcerations but would not involve the stomach and duodenum.

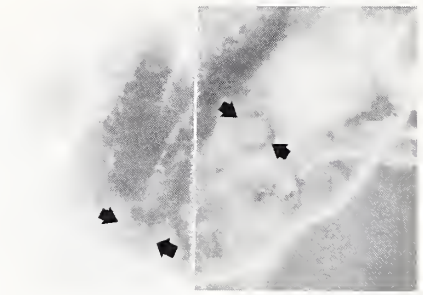


Figure 4: Ulcerations with halos (arrows) of the stomach in patient with lymphoma might be confused for aphthous ulcers, if not for their larger and variable size.

Candida Albicans

Candida albicans is a saphrophytic organism which commonly inhabits the gastrointestinal tract from mouth to anus in normal individuals. In the immunocompetent patient the organism is not a pathogen, but in immunocompromised states, diffuse candidal gastrointestinal involvement may occur. Initially, involvement presents as small, raised plaques that commonly ulcerate.[6] With progression, blood vessels become involved and septicemia and thrombosis sometimes results. The initial radiographic appearance is that of superficial ulcerations indistinguishable from aphthous ulcers and represents the earliest detectable evidence of candidal involvement.[6] The three patients presented here were previously healthy and would not be immunocompromised.

Ulcerative Colitis

The radiographic features distinguishing Crohn's disease from ulcerative colitis are well known. In ulcerative colitis early involvement is characterized by fine granularity secondary to mucosal edema and superficial ulcerations. It usually begins in the rectum and extends proximally to involve the colon in a continuous fashion. Other features include pseudopolyp formation, a normal terminal ileum and an increased incidence of carcinoma. Duodenal and gastric involvement is rare. Aphthous ulcers do occur but much less frequently than in Crohn's disease.

Crohn's Disease

Aphthous ulcers are the earliest lesions in Crohn's disease and have been demonstrated by double-contrast studies in the stomach, small bowel and colon.[7] They may progress to multiple networks resulting in a cobblestoned mucosa and pseudopolyps. Abscess and fistula formation are frequent complications. Patchy involvement or skip lesions where diseased bowel alternates with normal bowel is the hallmark of this disease. Therefore, in these three patients with aphthous ulcers involving the stomach, duodenum and colon, Crohn's disease is the most likely diagnosis.

Aphthous Ulcers

Hippocrates referred to the focal lesions found in thrush as aphthae. The term was later applied to any tiny ulcer. The gross appearance of gastrointestinal aphthous ulcers is similar to those in aphthous stomatitis. This was recognized in 1953 by Brooke,[8] who described a characteristic pattern of colonic ulcerations in Crohn's disease as being "aphthoid." They appear radiographically as punctate collections of barium varying from 1-3mm in diameter with a surrounding halo of edema.[9]

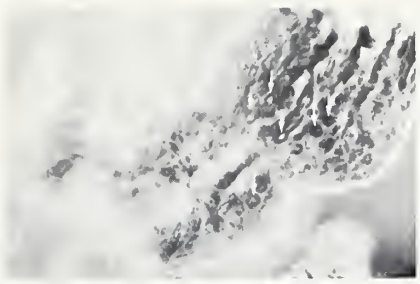


Figure 5: Numerous small ulcerations (arrowheads) of the stomach in patient with erosive gastritis. The surrounding black halos represent the slightly raised inflammatory edge.

of the colon may precede severe disease by period of years. However, their presence does not invariably indicate early disease, as widespread ulcerations have also been detected years after demonstration of severe disease.[7]

Similar ulcerations have been detected in ulcerative colitis, but they are much less common than in Crohn's disease. In fact, Morson has not seen such lesions on pathological examinations of excised specimens.[7]

The frequent association of these ulcers with Crohn's disease may lead to a failure to consider other diagnostic possibilities. Aphthous ulcers have been detected in multiple disease processes (Table 1), which reflects the nonspecificity of this radiographic finding.

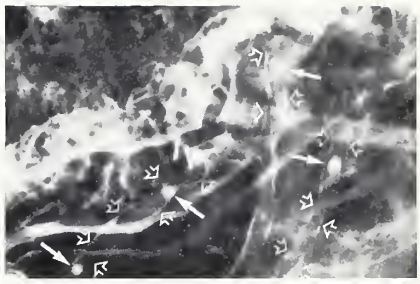


Figure 6: Normal barium droplets (arrows) hanging from non-dependent gastric folds (open arrows) etched in white may simulate aphthous ulcers. Lack of surrounding halo and reproducibility are differentiating features.

Histologically, there is a discrete ulceration in the basal portion of the lamina propria underlying a lymphoid follicle. These nodules may be hyperplastic and contain giant cells or granulomas.[10] The surrounding submucosa is often edematous and demonstrates varying degrees of lymphectasia. Neutrophils and mucous are contained within the ulcer crater and there is epithelial proliferation at its margins.[10]

The etiology of aphthous ulcers is speculative. One theory is that these minute lesions may represent the body's initial site of reaction to a transmissable agent or its site of entry.[11] Electron-microscopic studies of patients with yersinia enterocolitis revealed organisms being engulfed by histiocytes in the smallest of these ulcerations.[9]

With the advent of double-contrast techniques, aphthoid ulcerations have become a characteristic finding primarily associated with Crohn's disease. These ulcerations probably represent the earliest pathological changes in Crohn's disease.[12] Aphthous ulcers have been seen in barium studies in the small bowel by careful compression techniques in 52.5% of cases, often adjacent to more apparent disease.[7] An incidence of 44-67% of these ulcers has been reported in Crohn's colitis.[13] Hence, the detection of these ulcers can lead to early diagnosis. Widespread ulcerations

Entities Associated with Aphthous Ulcers

- Inflammatory Bowel Disease
 - Crohn's disease
 - Ulcerative colitis
- Infectious Diseases
 - Mycobacterium tuberculosis
 - Candidiasis
 - Yersinia entercolitica
 - Amebiasis
 - Herpes simplex
 - Campylobacter fetus
 - Shigellosis
- Ischemic colitis
- Oral contraceptives
- Coeliac disease
- Bechet's disease
- Normal lymphoid follicular pattern
- Leukopenia
- Polyarteritis nodosa
- Barium artifacts
- Idiopathic

Many infectious agents have been associated with aphthous ulcers (Table 1).[13-16] These lesions have been detected in Bechet's disease and may indicate true involvement of the colon by Bechet's disease, associated autoimmune abnormalities or Bechet's disease and coincidental colitis.[17]

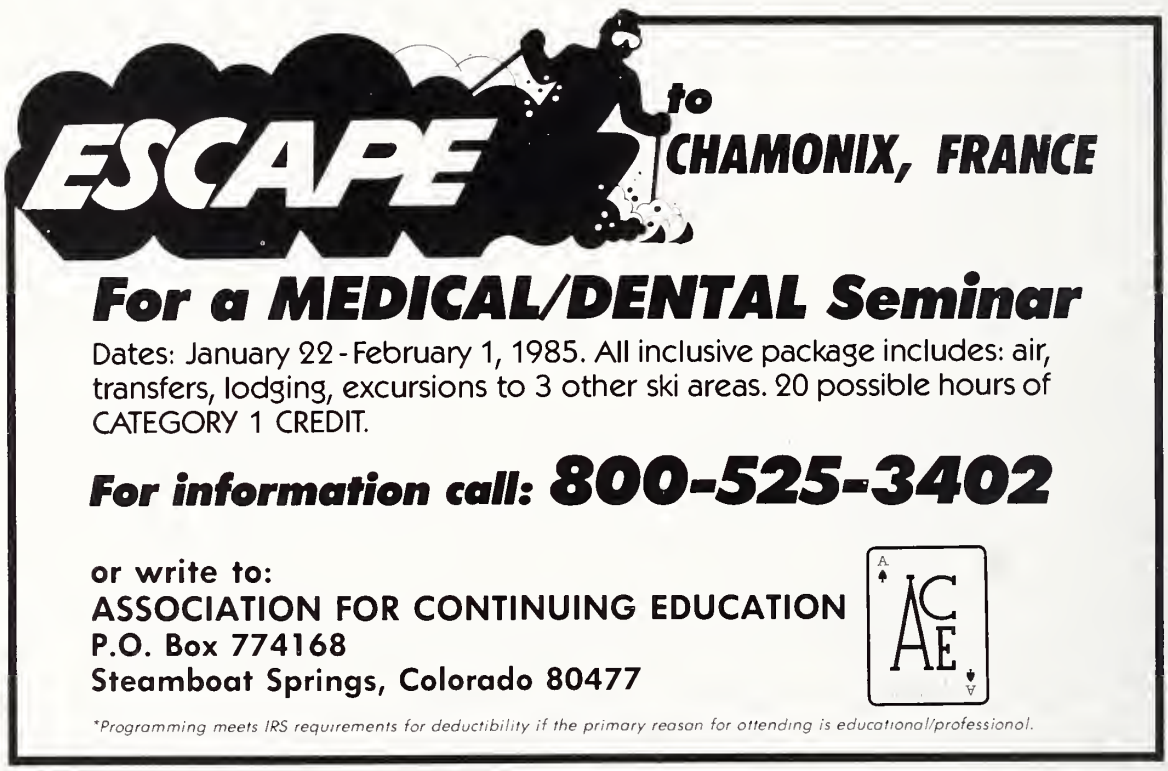
Discrete ulcers in the mouth and small intestines sometimes occur in coeliac disease. No effective medical therapy is known and often surgical resection is needed as perforation may occur.[18]

Punctate barium artifacts and multiple cavitary polypoid lesions (Figure 4) may have similar radiographic appearances. Barium artifacts do not have a surrounding lucent halo and cavitary nodules are larger than aphthous ulcers. Aphthous ulcers are occasionally seen in leukopenic patients and with superficial chronic gastritis (Figure 5) due to either aspirin or ethanol.[13,19] Aphthous ulcers have also occurred with polyarteritis nodosa. In some cases, they may be idiopathic.[19] ◀

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Black Enterprise	10.00	6.00
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Brides	12.00	9.00
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Dog World	18.00	15.95
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Forbes	39.00	26.00
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	100 wks.	49.00
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ILM011

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Public Health

Copies of *The Prevention and Treatment of Five Complications of Diabetes: A Guide for Primary Care Practitioners* are available without charge from the Department of Public Health Diabetes Control Program. The *Guide* has been prepared under the auspices of the National Diabetes Advisory Board, and is designed to assist the primary care physician in the day-to-day management of patients with diabetes.

The *Guide's* recommendations relate to diabetic visual impairment, adverse outcomes in pregnancy, foot problems, kidney problems, acute hyperglycemia and ketoacidosis. Background, prevention, detection and monitoring, treatment and referral and patient education principles are summarized for each complication.

Patient education materials summarizing key elements for each complication may be copied and given to patients. One-page summaries of recommendations may be photocopied and placed in patient records.

To obtain a copy, write to Mrs. Ruth Green, Diabetes Control Program, IDPH, 535 West Jefferson, Springfield, IL 62761 or telephone either a regional IDPH office or the Springfield office (217/782-3300).

A series of slides and a manuscript, to complement the *Guide*, are available for CME programs. Contact the offices listed above for loan requests.

(Source: Correspondence from IDPH Acting Director)

From the Department of Registration and Education

The actions involving the following physicians have been taken by the Director of the Department of Registration and Education:

- *Brian E. Briggs, M.D. (Lic. #36-058583)* On October 2, 1984, the Director signed an order revoking the medical license of Dr. Briggs.
- *William L. Daugherty, M.D. (Lic. #36-32985 & 3-36-32985-1)* Effective August 16, 1984, Dr. Daugherty's license to prescribe, dispense or distribute Schedule II Controlled Substances was suspended for an indefinite period, along with other conditions agreed to in a consent order.
- *John R. Grow, M.D. (Lic. #36-54180 & 3-36-54180-1)* A consent order was signed by the Director under which Dr. Grow agreed to have his medical and controlled substances licenses suspended, effective September 10, 1984.
- *Lewis Jones, M.D. (Lic. #036-048203)* On July 20, 1984, the Director denied Dr. Jones' application for a controlled substance license.
- *Arnold P. Kallen, M.D. (Lic. #36-57809 & 3-36-57809-1)* Under a consent order signed by the Director on October 2, 1984, Dr. Kallen's license to prescribe, dispense or distribute controlled substances was suspended for an indefinite period. His license to practice was placed on probation for an indefinite period.
- *Francis H. Ketterer, M.D. (Lic. #36-20042 & 3-36-20042-1)* Under a consent order signed by the Director on September 5, 1984, Dr. Ketterer's controlled substance license was placed on probation with restriction on his prescribing of controlled substances.
- *Robert G. Knapp, M.D. (Lic. #36-66792 & 3-36-66792-1)* On October 2, 1984, the Director signed a consent order placing Dr. Knapp's license as a physician on probation for two years and placed his controlled substance license on probation for two years, with restrictions.
- *Paul S. Nierenberg, M.D. (Lic. #36-22581 & 3-36-22581-1)* Effective August 16, 1984, Dr. Nierenberg's license to prescribe, dispense or distribute Schedule II Controlled Substances was suspended for an indefinite period, along with other conditions agreed to in a consent order.
- *Arthur Polussa, M.D. (Lic. #003-036-66885)* On June 27, 1984, the Director signed a consent order under which Dr. Polussa agreed to have his controlled substance license suspended from February 14, 1984—February 14, 1985. During this period, the physician may prescribe only Class V controlled substances.
- *Steven Shellabarger, M.D. (Lic. #036-43788)* On October 2, 1984, the license of Dr. Shellabarger was restored from probation.
- *James H. Taylor, M.D. (Lic. #3-36-21374-1)* On July 23, 1984, the Director signed an order revoking Dr. Taylor's controlled substance license.
- *William Yacullo, M.D. (Lic. #003-036-023227-1)* On October 2, 1984, the Director signed an order suspending Dr. Yacullo's controlled substance license, except for prescribing Empirin with Codeine.

(Source: Orders received by ISMS from the Department of Registration and Education)

CLASSIFIED ADVERTISING

Classified Advertising Rates

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POSITIONS AND PRACTICE

FAMILY PRACTITIONER/INTERNAL MEDICINE—To locate in Rosiclare, Illinois. 49-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. Contact Roby Williams, Administrator, P.O. Box 467, Rosiclare, IL 62982. (618) 285-6634.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialties in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full and part time opportunities for well qualified emergency physicians in a northwest Chicago suburb. Excellent compensation package. Respond with C.V. to: Debbie Hibberts, EMSA, 8200 W. Sunrise Blvd, Bldg. C, Plantation, FL 33322 or call collect (305) 472-6922.

MEDICAL DIRECTOR. Opportunity for physician with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, I South Park St., Madison, WI 53715; phone 608-251-4156.

FAMILY PRACTICE. Rapidly expanding staff model HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; 608-251-4156.

OB/GYN. Group Health Cooperative has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; phone 608-251-4156.

OBSTETRICIAN-GYNECOLOGIST needed for prosperous community of 12,000 which is 1½ hours from the Chicago Loop in central Illinois. Minimum guarantee $150,000. Please submit CV to Bromley and Associates, 1010 Jorie Blvd., Suite 234, Oak Brook, IL 60521, or phone 312-986-5870.

CHICAGO: Experienced Family Practitioner wanted for Hospital Affiliated Clinics in southwest suburban areas. Regular hours, no night call. Minimum guarantee $90,000 with fee-for-service. Call or send CV to: Dr. Horton, 179 W. Washington, Suite 1100, Chicago, IL 60602, or call (312) 372-1539.

INTERNIST/BOARD ELIGIBLE or certified with subspecialty in infectious diseases wanted to join the busy, suburban practice of a solo internist. Excellent potential for rapid growth. Send curriculum vitae to Box #1128, c/o the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

INTERNIST—Looking for added income opportunity with no financial investment? Board Certified Internists required for disability examinations in downstate Illinois locations. Reply to Box #1135, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

INTERNIST: B/C-B/E to join well established group immediately, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

FAMILY PRACTITIONER: B/C-B/E to join well established group immediately, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

BE OR BC INTERNIST with subspecialty in Infectious Diseases needed to join busy solo internist practicing in suburban Chicago area. Very good potential for rapid growth. Send CV to Box #1134, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GENERAL SURGEON—Board certified or Board eligible. To join eight member family practice medical center. Have full-time radiologist. Major specialties consult on regular basis. Located at International Falls in northern Minnesota. Near Voyageurs National Park. Year around outdoor recreation abounds. Served by major airline. Population twenty thousand. Send curriculum vitae to Dr. James R. Schuft, Falls Medical Center, Shorewood Drive, International Falls, Minnesota 56649.

CARDIOLOGIST: Opportunity to practice cardiology with well-established practice conveniently located to a large teaching hospital. Duties include supervising and interpreting Treadmills, Holter monitors, 2D and M-Mode Echocardiography performed in office, patient examinations, hospital rounds and cardiac catheterizations. Abilities to do streptokinase and/or angioplasty desirable. Excellent beginning salary and fringe benefits. Located in Pennsylvania. Immediate Opening. Reply with C-V to Box #1132, c/o

the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GENERAL/FAMILY PRACTICE Southern California CIGNA Healthplans of California has over 28 facilities in Los Angeles and Orange County and more than 350,000 members. Our 370 full-time physicians enjoy a personal patient population and continuity of care. Significant growth has created opportunities for experienced specialists and General and Family Practitioners to join our professional team and share in our excellent compensation and benefits package. For more information send curriculum vitae to Director/Physician Recruitment: CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500, Glendale, CA 91203.

ANTERIOR SEGMENT FELLOWSHIP in busy private practice associated with Medical College. Intraocular Lens Implantation, including posterior chamber and anterior chamber lenses. Extracapsular and Phacoemulsification techniques. Argon & Yag Laser. Excellent benefits plus fringes. Send CV and career objectives to Box #1139, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FAMILY PRACTICE-INDUSTRIAL MEDICINE a balanced practice awaits you in beautiful S.E. Wisconsin. Associate needed to share this rapidly growing practice. Contact Westmound Clinics, 683 Westmound, Waukesha, WI 53186 (414) 549-9100.

OB/GYN ASSOCIATE—OB/GYN seeks an agressive, patient oriented, board certified/eligible associate, with 1-3 years of post residency experience, to join successful practice located in the affluent western suburbs of Chicago. Individual selected will enjoy our hospital's liberal financial support program. For confidential consideration, please respond with CV to; Mr. Dengler, West Suburban Hospital Medical Center, Oak Park, Il 60302.

FAMILY PRACTICE PHYSICIAN, ALLERGIST, DERMATOLOGIST, RHEUMATOLOGIST—Exceptional practice opportunities for these specialists in a midwestern industrial community of 140,000 population. Excellent educational system including a local university and area technical school. Professional office space adjacent to 260-bed modern, well-equipped hospital. Send C.V. to Box 1141, *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

OBSTETRICIAN/GYNECOLOGIST—Board certified or eligible, to join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Frank H. Descourouez, M.D. or Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

INTERNIST—Board certified or eligible, to join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Frank H. Descourouez, M.D. or Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

LOCUM TENENS position available for Family Practitioner for the months of January through May 1985 at CIGNA Healthplan, an established, growing, progressive prepaid group practice in Phoenix, AZ. An opportunity to practice in a desirable environment coupled with a leisurely southwestern lifestyle. Please submit CV to: Director, Physician Recruitment, CIGNA Healthplan, P.O. Box 44678, Dept. LTI, Phoenix, AZ 85064, (602) 954-3506. EOE

EXCELLENT OPPORTUNITY for family physician to join growing northside medical group. Equity position in medical corporation available. No OB or Surgery. Membership on university affiliated hospital staff assured. Compensation $60,000 including benefits. Reply with resume to Box #1143, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MULTI-SPECIALTY GROUP thirty miles southwest of Chicago seeks board eligible obstetrician-gynecologist to join expanding practice. Incentive plan, profit-sharing, relatively new building. Excellent practice opportunity with above average grade and high schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, IL 60423, (815-469-2123).

GENERAL SURGERY RESIDENCY Program Director needed by 210 physician multispecialty group practice in central Wisconsin. Board certified general surgeons with subspecialty training in peripheral vascular surgery plus strong academic interests are being considered. This surgeon would join a seven member general surgery section with subspecialty expertise. A clinical appointment through the University of Wisconsin Medical School is available. Call Gail H. Williams, M.D., Surgery Department Chairman, or Sidney E. Johnson, M.D., Medical Director, collect at (715) 387-5609 and (715) 387-5253 respectively, or send curriculum vitae to: Gail H. Williams, M.D., Chairman, Department of Surgery, Marshfield Clinic, Marshfield, WI 54449.

WISCONSIN Central: One or two emergency physicians sought for fully accredited 164-bed facility. Current staffing includes three full-time physicians, one to retire shortly. Other opening created through phaseout of resident coverage. FFS corporation to be developed within a year. Over 15,000 annual visits. Newly renovated ED is spacious and well equipped. Complete specialty support. Community of 25,000 offers year-round recreational opportunities. Compensation 80K+ plus benefits. For further information contact Tom Campbell, Fox Hill Associates, 414/785-6500 or 414/662-4145 (home) collect.

MICHIGAN, Upper Peninsula: Full-time emergency position available with an expanding department which has medium volume ED visits. Independent contractual relationship. Flexible scheduling and annual compensation of at least 78K. Previous ED experience and family practice or surgery background desired. Write or call Tom Campbell, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, 414/785-6500.

POSITION AVAILABLE: Assistant professor of obstetrics and gynecology and supervisor of In vitro fertilization (IVF) laboratory. Duties include academic instruction, research and supervision of the IVF laboratory. Applicants must have a Ph.D. in physiology or biology and 1-2 years university level teaching experience. Knowledge of human IVF techniques and laboratory management are essential. Salary commensurate with experience. Submit curriculum vitae and cover letter to W. Paul Dmowski, M.D., Ph.D., Director, Section of Reproductive Endocrinology and Infertility, Rush Medical College, 600 S. Paulina Street, Chicago, Illinois 60612. Equal Employment Opportunity/Affirmative Action Employer.

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GOOD GENERAL OR INTERNAL MEDICINE practice wanted in Chicago or southwest suburb. Reply to Box #1133, c/o the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GASTROENTEROLOGIST, Board Certified with 3 years of clinical experience, seeks practice opportunities in Northern Illinois. Reply Box #1138, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

INTERNIST, certified, seeking full time or part time position in Chicago or suburbs. Certified in gastroenterology and life insurance medicine. Master of business administration degree (hospital administration). Will consider internal or occupational medicine, student or employee health, medical underwriting or administration. Write to Box #1145, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED family practitioner, 2 yrs experience, seeks association with single or multispecialty group, or well established practice to buy in Chicago northwest suburb. Write to Box #1142, c/o the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602, or call (312) 763-0723.

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MEDICAL PRACTICE FOR SALE in South Chicago area with all equipment and furniture. Grossing over $100,000. Pharmacy on premises. Reasonable terms. Call 312-339-7700 between 2 pm and 6 pm.

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FOR SALE HAZELCREST: Combined Doctor's fully equipped office plus home; completely A.C.; 3 bedrooms; 2 car garage; lot adjacent to building for future expansion. Near 5 hospitals. Shown by appointment. (312)389-4343 after 5 P.M.

TINLEY PARK MEDICAL CENTER: For Sale. Full equipment. On main street. Parking, Doctor's private parking—garage. Lot adjacent to office for future expansion. Near five hospitals. Shown by appointment. (312)389-4343 or (312)532-3900 after 5 p.m.

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MEDICAL OFFICES & SUITES For Rent: Lincoln-Belmont-Ashland, Chicago, IL 200-1200 sq ft, professional bldg. Elevator, Full service janitorial staff, central heat & A/C. Gary Solomon & Company, 312/334-5400.

FAR NORTHWESTERN ILLINOIS general practice grossing approx. $250,000. Both practice and real estate available for $200,000. Dr. seeing 25-30 patients daily. Located in beautiful area. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093, (312) 441-6111.

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Homes for sale, nationwide selection, high growth areas. Accelerated eighteen year depreciation schedule. Low cash down, discounted closing costs. Property management and financing available. Rent guaranteed for 1st 12 months. Prices from $50,000. (312) 965-9016, EPIC Residential Network, Inc.

CHOICE OFFICE SPACE Available—Elmwood Park-River Grove Area. Small medical building. Good transportation. 7700 on Belmont Ave. Call Mark: weekdays-(312) 625-4221 for appointment.

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1985 CME CRUISE/CONFERENCES on selected medical topics—Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days year-round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. Fly roundtrip free on Caribbean, Mexican, & Alaskan Cruises. Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, NY 11746. (516) 549-0869.

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BRUMBY AND MELSON ROCKERS® available by mail for home and office. Also other fine rocking chairs in wood and leather. Write for our free catalog. The Rocker Shop™ of Marietta, GA, P.O. Box 12, Dept. ILS, Marietta, GA 30061, (404) 427-2618.

EKG

(Continued from page 316)

Answers: 1. A, B 2. B, C

The top strip shows a sinus rhythm in the first five beats with a gradually and slightly prolonging PR interval. This is an AV Wenckebach sequence. The next three beats are junctional escape beats in a slow junctional rhythm at a rate of 42 beats per minute. This is AV dissociation. The last beat in the top strip is a sinus capture beat. This represents advanced or high grade AV block, *i.e.*, more than isolated dropped beats but less than complete AV block. The second strip shows complete AV dissociation due to complete AV block. No P wave is conducted to the ventricles. The slow junctional rhythm is again about 40 beats per minute. The bottom strip shows a well functioning ventricular pacemaker with amplitude changes in the pacemaker spike probably due to respiration.

The development of heart block in the setting of infective endocarditis is ominous but fortunately rare. Complete heart block complicating endocarditis reportedly occurs in up to 4% of cases while lesser degrees of AV block occur more often. The development of heart block in endocarditis is ominous because it is often associated with myocardial abscesses and a high mortality. Heart block is seen more often in aortic valve endocarditis, probably because of the close anatomic proximity of the cardiac conduction system and the right and non-coronary cusps of the aortic valve. When these myocardial abscesses are found in the valve ring, they may be difficult to treat medically. Active infection may persist there and require surgical debridement and aortic valve replacement. Organisms associated with heart block in endocarditis include staphylococcus, streptococcus, viridans, enterococci, and *E coli*. The presence of complete heart block requires a pacemaker. The presence of severe congestive heart failure made the surgery emergent. At the time of surgery, the ascending aorta was markedly dilated. The aortic valve was bicuspid with fusion of the right and left coronary cusps. After the aortic valve was removed, a deep abscess cavity was found burrowing into the interventricular septum. A prosthetic valve and a permanent pacemaker were inserted. The patient had an uneventful postoperative course and is presently doing well. For more information on this topic, see Arnett and Roberts, "Valve Ring Abscess in Active Infective Endocarditis," *Circulation* 54:140, 1976. ◂

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PRESIDENT'S PAGE



Onward

At year's end, the holiday season brings a few thoughts to mind.

Fortunately, 1984 really did not fulfill Orwell's predictions, although he was not far wrong in some areas.

We had our ups and downs in the legislative area. Our successes show that it can be done; we can learn from our failures and, hopefully, turn them into successes next year.

Economically, we found that the federal government continues to be a formidable, although not invincible, opponent. Cooperation with our state government has been excellent, however.

I believe our recently completed, now annual, Leadership Conference in Rockford was quite successful in terms of both content and attendance. It should result in added knowledge and expertise to use in our legislative initiative against malpractice, beginning now.

In all areas we will continue to be the patient's advocate, although others would like to share that role.

We have lots to accomplish in 1985. Working together as a united Society, I know that we will be successful more often than not.

May I wish each and every one of you fellow members, your families, and staffs, the best of holiday seasons and a healthy and fulfilling year in 1985. ◂

Robert C. Hamilton, M.D.
President



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) *LONG ACTING CAPSULES*



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Precautions Against Transmittable Disease

By Karen S. Kawala, MSS Delegate to the ISMS House of Delegates/Chicago

At the 1984 AMA Annual Meeting in Chicago, the Medical Student Section proposed a resolution designed to further publicize guidelines for health care workers caring for patients with potentially transmittable diseases. Material on this subject is readily available to most hospital personnel; however, the AMA-MSS found a deficit in information dissemination among a portion of its medical students. This article is aimed at providing basic guidelines as well as literature sources for further reference.

Acquired Immune Deficiency Syndrome (AIDS) has become a controversial health issue. The incidence of AIDS has been steadily rising: 58 diagnosed cases before 1981; 231 cases in 1981; 883 cases in 1982; and 1087 cases as of September 1983.[1] The mode of AIDS transmission has not been proven; however, its prevalence among homosexuals, IV drug users, hemophiliacs, sexual partners of members of these groups and recipients of blood transfusions suggest that it is transmitted either sexually, through contaminated needles or blood.[2]

Because the mode of disease transmission is unknown, concern has arisen among medical students, technicians, hospital house staff and physicians as to what precautions should be taken when caring for AIDS patients.[3] The Center for Disease Control has published recommended precautions for clinical and laboratory personnel.[4]

Presenting signs of a patient with a possible diagnosis of AIDS include opportunistic infections not associated with steroid treatment or underlying immunosuppressive disease, Karposi's sarcoma, chronic generalized lymphadenopathy, unexplained prolonged fever in a patient at risk, and unexplained weight loss. The same precautions implemented for diagnosed AIDS patients should be used for patients suspected of having AIDS. These precautions are also applicable to other transmittable diseases, such as hepatitis B virus infection.[5] A synopsis of the CDC precautions for clinical personnel (exposed to patients with proven or probable transmittable disease) includes the following:

(1) Avoid accidental wounds and protect open skin lesions from contaminated materials.
(2) Gloves and gowns should be worn when handling objects exposed to blood, body fluids, excretions or secretions.
(3) Wash hands thoroughly before leaving patient's room.
(4) Label *all* specimens *and* soiled articles with a special warning such as "Blood Precautions" and place the container in a second impervious container.
(5) Clean up blood spills immediately with disinfectant such as sodium hypochlorite.
(6) Disposable syringes and needles are preferred and should be promptly disposed of in a puncture-resistant container.
(7) A private room is indicated for patients who are too ill to use good hygiene, such as those with diarrhea, incontinence, or altered behavior secondary to central nervous system infections.

These precautions do not specifically address outpatient care, dental care, surgery, necropsy or hemodialysis of AIDS patients. Patient care and laboratory personnel in any setting should take precautions to avoid direct contact of skin and mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS.[6] This may include masks when attending to a coughing patient or eye wear in case of splatter with contaminated fluids. All equipment and instruments should be sterilized before and after use. Common sense is essential in protecting oneself and others while treating patients with potentially transmittable diseases.

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1. Centers for Disease Control: "Update: Acquired Immunodeficiency Syndrome (AIDS)—United States," *MMWR* 32:465-467, 1983.
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5. Solomon, S.L.: "AIDS: Risk of Transmission to Medical Care Workers," *JAMA* 251-397, 1984.
6. Centers for Disease Control: "Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health-Care Workers and Allied Professionals," *MMWR* 32:450-451, 1983.

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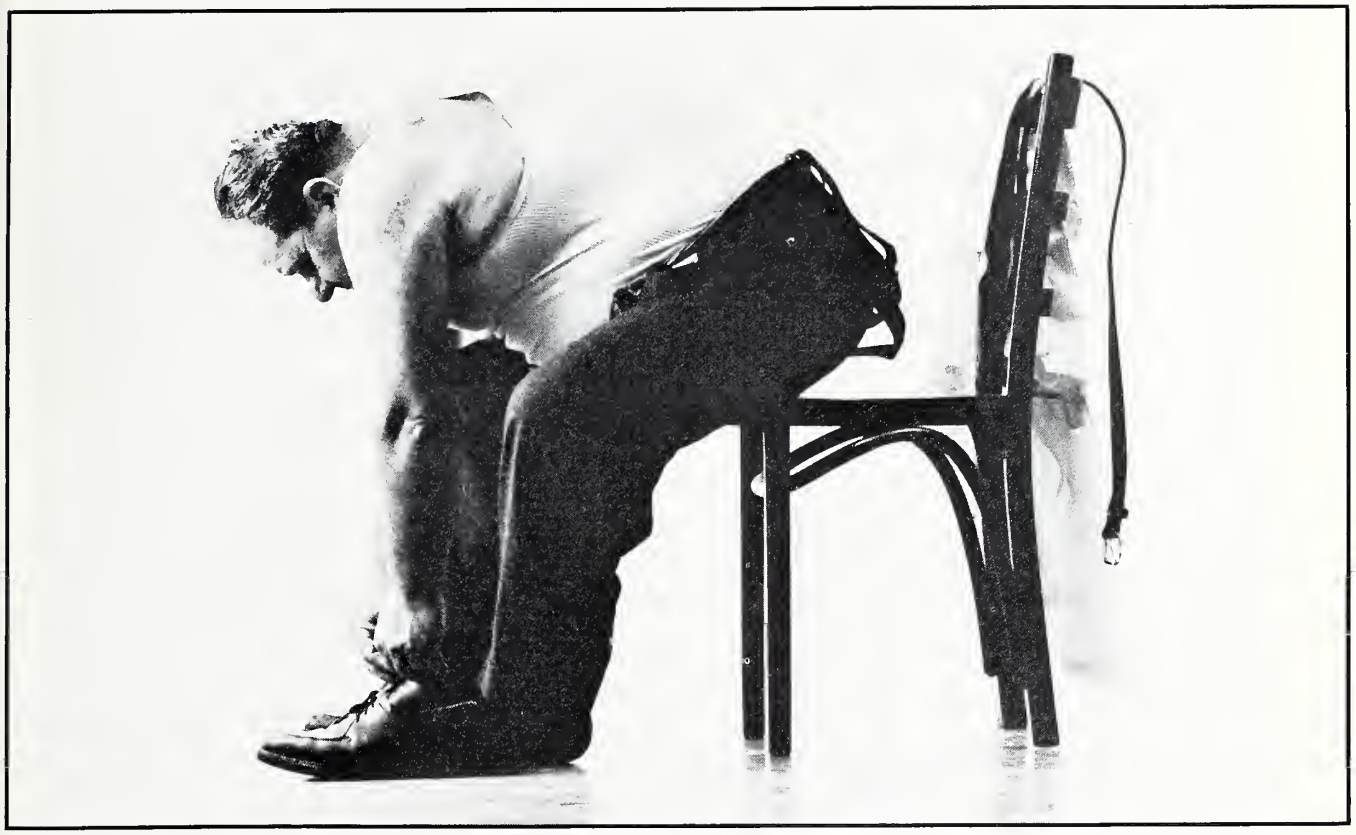
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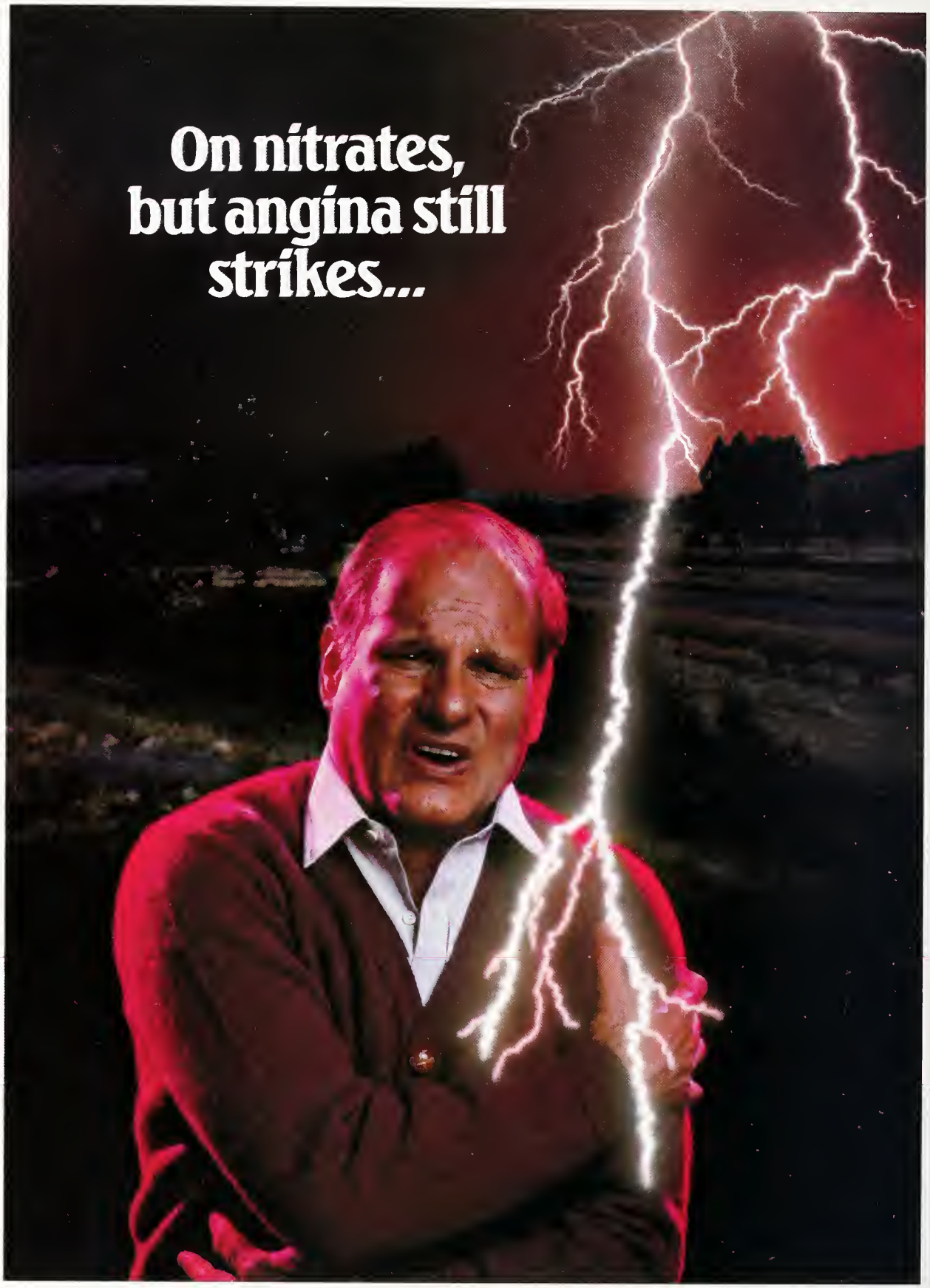
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80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

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Obituaries

***Albrecht, Armand D.,** Naperville, died November 3 at the age of 68. Dr. Albrecht was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

****Balsamo, Nicholas J.,** River Forest, died October 21 at the age of 77. Dr. Balsamo was a 1932 graduate of the Loyola University Stritch School of Medicine.

****Crandle, Ellis R.,** Carbondale, died October 5 at the age of 79. Dr. Crandle was a 1933 graduate of the St. Louis University School of Medicine.

****Gutzmer, Charles A.,** Oak Brook, died November 4 at the age of 80. Dr. Gutzmer was a 1934 graduate of Northwestern University Medical School.

****Jaffray, David S.,** Chicago, died October 17 at the age of 76. Dr. Jaffray was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

***Laufer, Guillermo,** Chicago, died October 12 at the age of 61. Dr. Laufer was a 1952 graduate of the Facultad de Medicina de la Universidad de la Habana, La Habana, Cuba.

***Milewski, Joseph G.,** Park Ridge, died October 16 at the age of 55. Dr. Milewski was a 1954 graduate of Akademia Medyczna, Gdansk, Poland.

Miller, Fred M., St. Joseph, Michigan (formerly of Chicago) died October 14 at the age of 92. Dr. Miller was a 1914 graduate of Bennett Medical College, Chicago.

Pullos, Nicholas S., Winnetka, died October 12 at the age of 39. Dr. Pullos was a 1970 graduate of the University of Illinois College of Medicine, Chicago.

***Samos, Ference Henry,** Chicago, died October 29 at the age of 58. Dr. Samos was a 1951 graduate of Medizinische Fakultat der Johann-Wolfgang-Goethe-Universitat, Frankfurt Am-Main, Hessen, Germany.

***Schneider, Howard W.,** Flossmoor, died October 17 at the age of 66. Dr. Schneider was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Graduate Medical Education and Medicare

This election year, the solvency of Medicare and its future have become prominent political topics. All areas of Medicare have been scrutinized. As a result, considerable discussion has taken place in Washington concerning Medicare reimbursement to teaching hospitals for graduate medical education. Currently there are three major forces acting on the Medicare segment (and indirectly other third party payors of health care) of graduate medical education.

1. The AMA, the AHA, and to a lesser degree, the AAMC, have been advocating the status quo. That is, maintaining current reimbursement mechanisms for teaching hospitals, which gives them a certain percentage above the set DRG rate for non-teaching hospitals in that demographic/geographic classification.
2. The Advisory Committee for Social Security has stated that Medicare is a service and was never meant to subsidize graduate medical teaching programs. However, their report acknowledged the importance of finding alternative sources of funding for teaching hospitals before ending Medicare's "contribution" to graduate medical education. This report offers no specific proposals; rather it advocates a philosophical approach to graduate medical education and Medicare.
3. Lastly (and most currently) the Inspector General's: "Report on Review of Cost of Resident's Services Reimbursed by Medicare," from the Department of Health and Human Services. Briefly, the report has two specific recommendations:
 a) Permit teaching hospitals to claim the cost of residents' patient care services for only the first year of residency.
 b) Permit reimbursement on a reasonable charge basis for physician services, whether provided by the teaching physician or resident (who has completed the first postgraduate year of training and met the state licensure requirements). The total charge for the combined services of the resident and teaching physician should not exceed the reasonable charge allowable for the same service in a non-teaching situation.

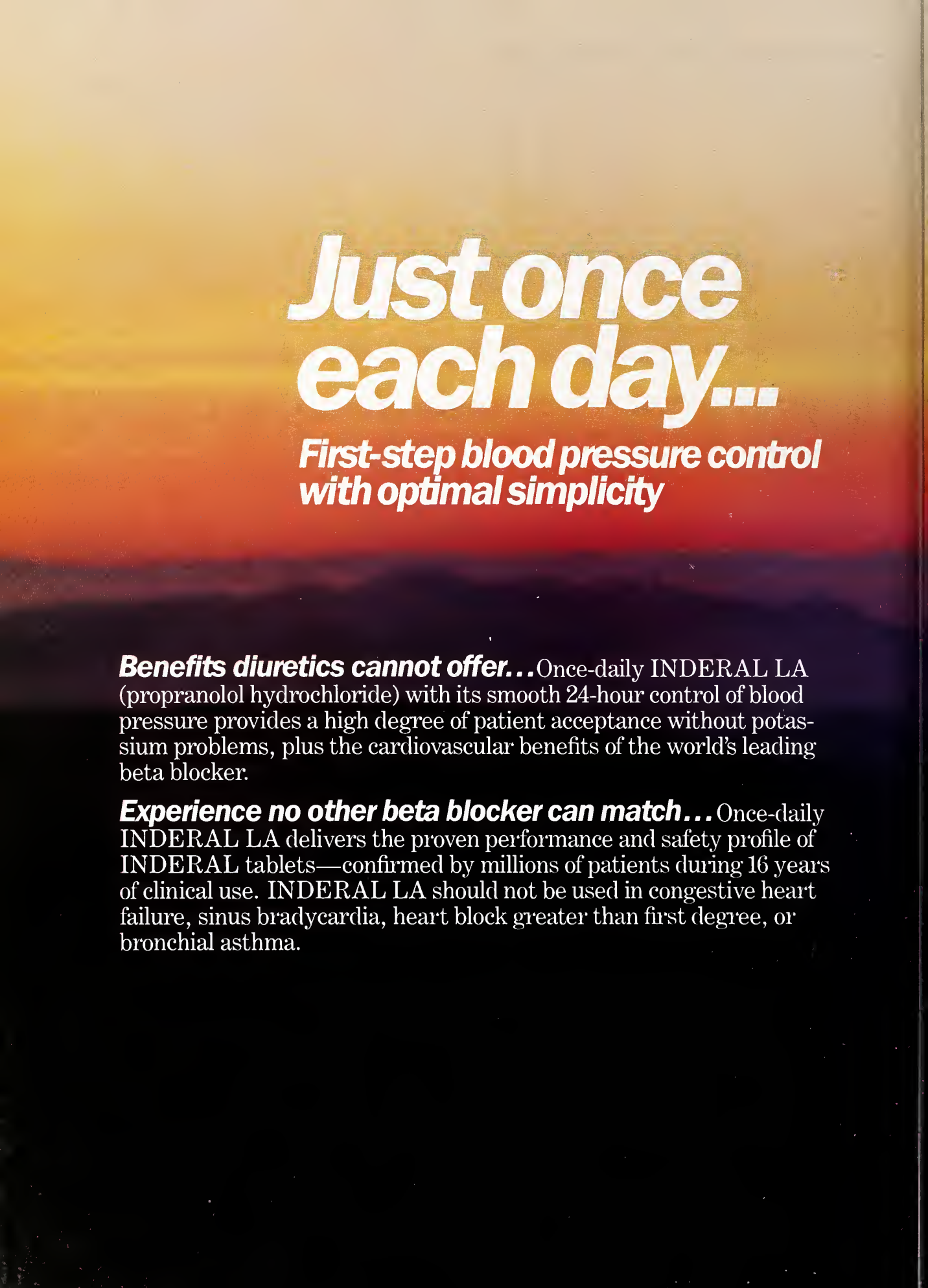
Other proposals are rumored to be in the works. However, the above are the only significant proposals that have been made public at this writing. Action on this area of Medicare has already begun; the Senate Finance Subcommittee on Health heard testimony on the topic in October of 1984. Final action is expected in the next year.

Of the above proposals, the Inspector General's report may carry the most weight behind it, because of its specific recommendations that would lead to an estimated $90 million in savings to Medicare. In view of the fiscal crisis of Medicare and the cost cutting trend of Washington, this is a tempting target.

The consequences of such a cut in Medicare without an alternative source of funding are difficult to predict. However, there is little question that it would have a serious negative impact on medical education and medical care in general.

The final decision on Medicare and graduate medical education will be decided on the floor of the House and Senate. Whatever the decision, the quality and direction of medical education will be significantly affected. ◀

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Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

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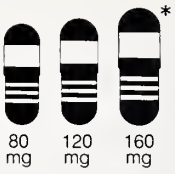
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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

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DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

The American College of Physicians (ACP) has announced that several Illinois physicians were among those recently elected to fellowship. They are: **Harold Bregman, M.D.,** Northbrook; **Andrew H. Cubria, M.D.,** Highland Park; **Mary Ann Emanuele, M.D.,** Palos Hills; **Daniel M. Kruss, M.D.,** Westchester; **Edmund J. Lewis, M.D.,** Chicago; and **Howard Vernof, M.D.,** Lincolnwood.

Seemin G. Khan, M.D., Northfield, received the Woman of Achievement in 1984 Award from the Evanston branch of the Illinois Federation of Business and Professional Women. The award is presented to a woman who represents the highest achievements in her profession or field of business and/or excels in academic studies and community service.

Philip H. Sheridan, M.D., Winnetka, was named the 1984 Founders' Day Award recipient at St. Francis Hospital, Evanston. Dr. Sheridan, a member of St. Francis' Board of Directors, was instrumental in the founding of the hospital's Galvin Heart Center. He was honored for "extraordinary humanitarian services to the hospital and the community."

John W. Ditzler, M.D., a former associate dean of Northwestern University Medical School in Chicago, is the Veterans Administration's new chief medical director. Dr. Ditzler served as chief of staff at Lakeside VA Medical Center and as associate dean of Northwestern from 1972 to 1976. As head of the VA's Department of Medicine and Surgery, Dr. Ditzler administers a medical system employing more than 200,000 health care personnel in 172 medical centers, 227 outpatient clinics, 105 nursing homes and 16 domiciliaries.

PREGNANCY AND WORK PERFORMANCE

Illinois physicians might wish to review recommendations of a recent AMA Council on Scientific Affairs report. Report H of the Council on Scientific Affairs was developed as a three part document and adopted at the 1983 annual meeting of the AMA. The complete document addresses many aspects of reproductive health. One of those three parts, "Effects of Pregnancy on Work Performance," was published in the April issue of the *Journal of the American Medical Association.* It offers suggestions regarding safe and healthful job placement for the patient during the various stages of pregnancy. Reprint requests may be addressed to the Division of Scientific Activities, Council on Scientific Affairs, AMA, 535 N. Dearborn, Chicago, IL 60610.

ONE IN FOUR PHYSICIANS HAVE FINANCIAL ARRANGEMENTS WITH HOSPITALS

Nearly 25% of all non-federal patient care physicians receive at least a part of their practice income by direct payment by hospitals or through lease arrangements, according to *SMS Report,* a publication of the AMA's Center for Health Policy Research. Female physicians and physicians in lower income categories are more likely to have salary contracts with hospitals, while male physicians and those in higher income classifications are more likely to have fee-for-service arrangements, according to the AMA Center.

PHYSICIANS MARTIAL ARTS ASSOCIATION REACTIVATED

An association for physicians active in the martial arts is being reactivated to promote martial arts medicine, make qualified physicians available as medical advisers to martial arts organizations, and conduct courses for instructors to help them recognize and handle injuries. Physicians interested in the Physicians Martial Arts Association should contact Millard Seto, M.D. at PMAA, PO Box 2175, Honolulu, Hawaii, 96805.

GET WELL WISHES FOR ISMS MEMBERS

The Illinois State Medical Society, concerned about members who become ill, would like to establish a mechanism to extend get well wishes. Persons who know of a member who is not well and might appreciate a greeting from the Society are encouraged to advise the division of membership/marketing in the ISMS offices: Twenty North Michigan Avenue, Suite 700, Chicago IL 60602; (312-782-1654).

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Educational Publications Available

Over the past several months, the Illinois State Medical Society has developed a series of informational items which should be of interest to physicians. Included in the Society's informational offerings are the following:

—*A Physician's Guide to the Illinois Living Will Act* which explains recent Illinois legislation providing for legal recognition of a patient's desire not to have life-sustaining actions taken if that patient has a terminal condition.

—*Due Process Guidelines for Physicians* which suggest provisions that hospital medical staffs should include in their bylaws regarding initial appointment to the staff, reappointment and discipline.

—*Guidelines for Hospital Medical Staff Bylaws* which are intended to help medical staffs write bylaws that recognize the appropriate responsibility and authority of the staff and its role with respect to the hospital and its own members.

—*Guidelines for Writing "Do Not Resuscitate" Orders* to assist hospital medical staffs in dealing with the now accepted practice of recognizing that in some clinical situations the initiation of life-prolonging treatment is inappropriate.

—*The Female Athlete: A Look at the Facts* which is a patient information brochure briefly describing myths and facts about participation in sports by women.

—*Don't Risk Your Child's Life* which describes safety features of infant car seats and encourages their use.

—*Guidelines for Hospital Committees to Assist Impaired Physicians* which describes the need for hospital committess to identify and deal with impaired staff members. Sample bylaws provisions are provided as are descriptions of different types of activities. The Society also publishes a pamphlet describing its program for impaired physicians and listing ISMS members who are available to provide counseling and referral.

—*Medical Emergency Cards* which are wallet-sized cards that permit patients to carry with them important medical information.

—*Mandatory Reporting Amendments to the Medical Practice Act* describes the Mandatory Reporting law and its implications. Included with the commentary are copies of the Act, rules and the reporting forms.

—*Guidelines for the Provision of Medical Care at Large Scale Events* provides an approach to planning and coordinating medical services for spectators and participants at large scale events.

Copies of the above items are available from ISMS headquarters. Information about costs and ordering procedures may be obtained by contacting the Society at Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602; (312) 782-1654. ◀



Transderm®-Nitro

(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)*

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
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5 mg/24 hr	25 mg	10 cm^2	7 Systems (NDC 0083-2105-07)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26)

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C84-7 (Rev. 2/84)

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information.)

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

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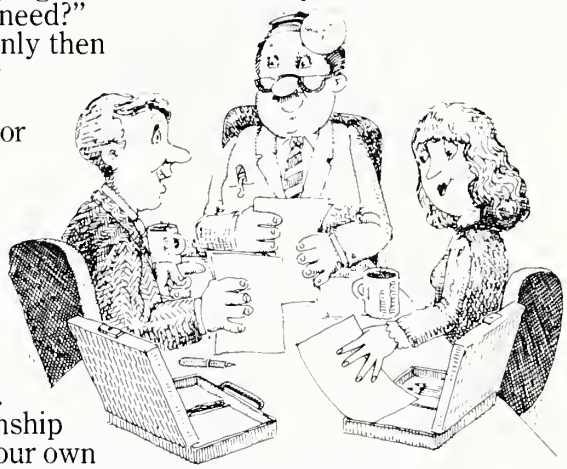
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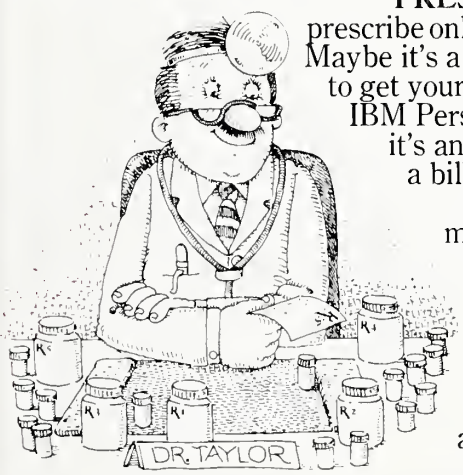
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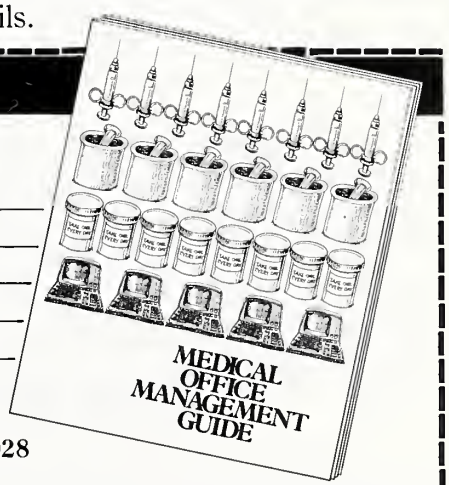
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IMJ-12/84

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This is a 77 year old patient who was brought to the emergency room by his wife after he suddenly stopped talking. She also noted he had right arm weakness and thought he was dragging his right leg when he walked. During the day, he had complained of frequent chest and left arm pains for which he took sublingual nitroglycerin tablets. There was a history of two previous myocardial infarctions. The patient could not speak but seemed to understand the questions. The lungs had bibasilar rales halfway up both lung fields and the cardiac rhythm was irregular with a ventricular gallop. There were right hemiplegia, right hemisensory loss and probably right homonymous hemianopsia. An echocardiogram was ordered. A previous twelve lead ECG showed atrial fibrillation and left ventricular hypertrophy with ST-T wave changes in part due to digitalis therapy. This ECG was taken in the emergency room.

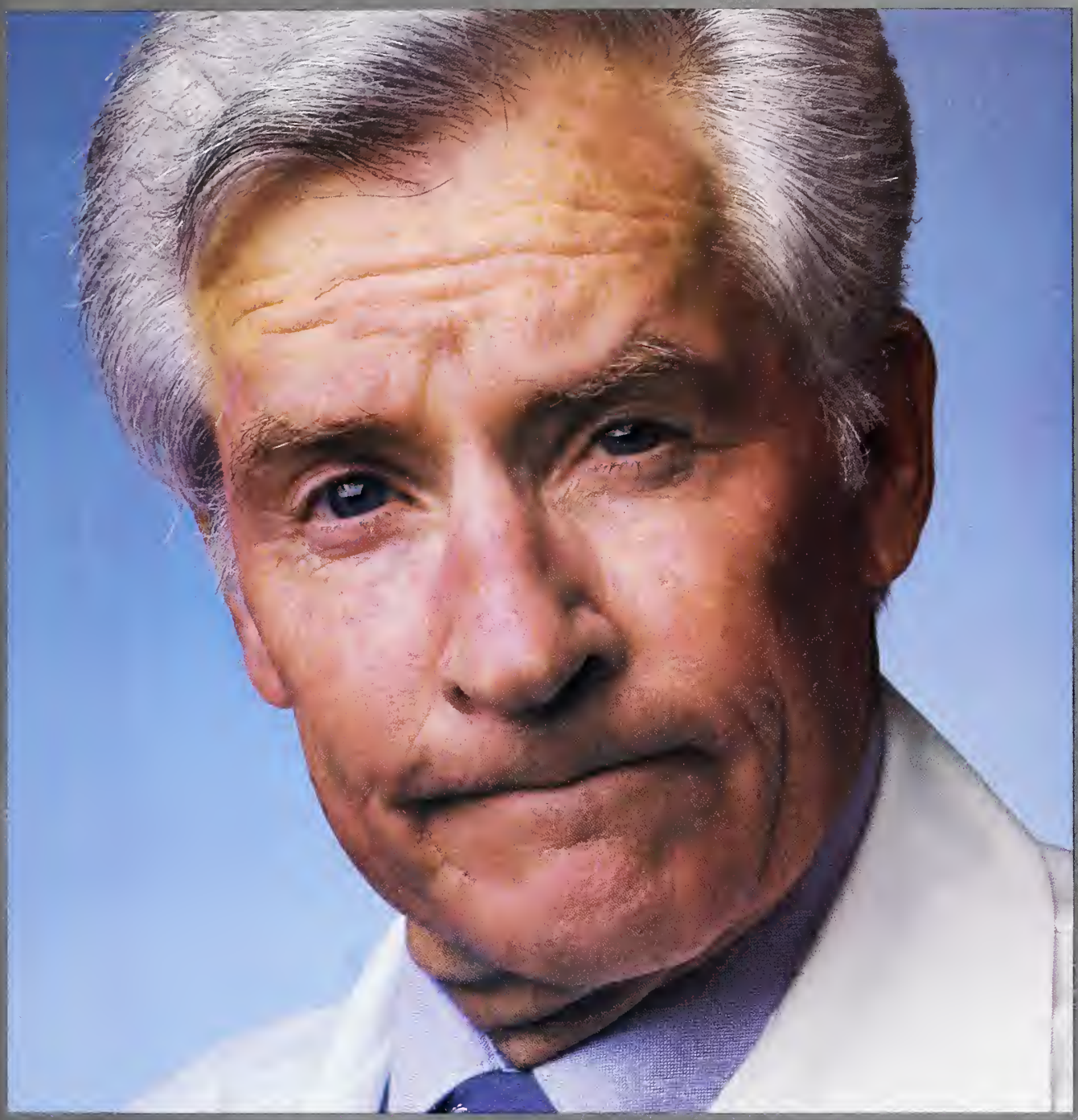


Questions:

1. This twelve lead ECG shows:
 a. An acute anteroseptal wall myocardial infarction.
 b. Atrial fibrillation.
 c. Complete left bundle branch block.
 d. Left axis deviation.
 e. All of the above.

2. The following statement(s) is/are true.
 a. This patient's cerebral vascular accident could be caused by a cerebral embolus.
 b. This patient's ECG is associated with a favorable prognosis.
 c. The echocardiogram could be helpful.
 d. The patient's history of previous myocardial infarctions is not significant at this time.
 e. All of the above.

(Continued on page 455)



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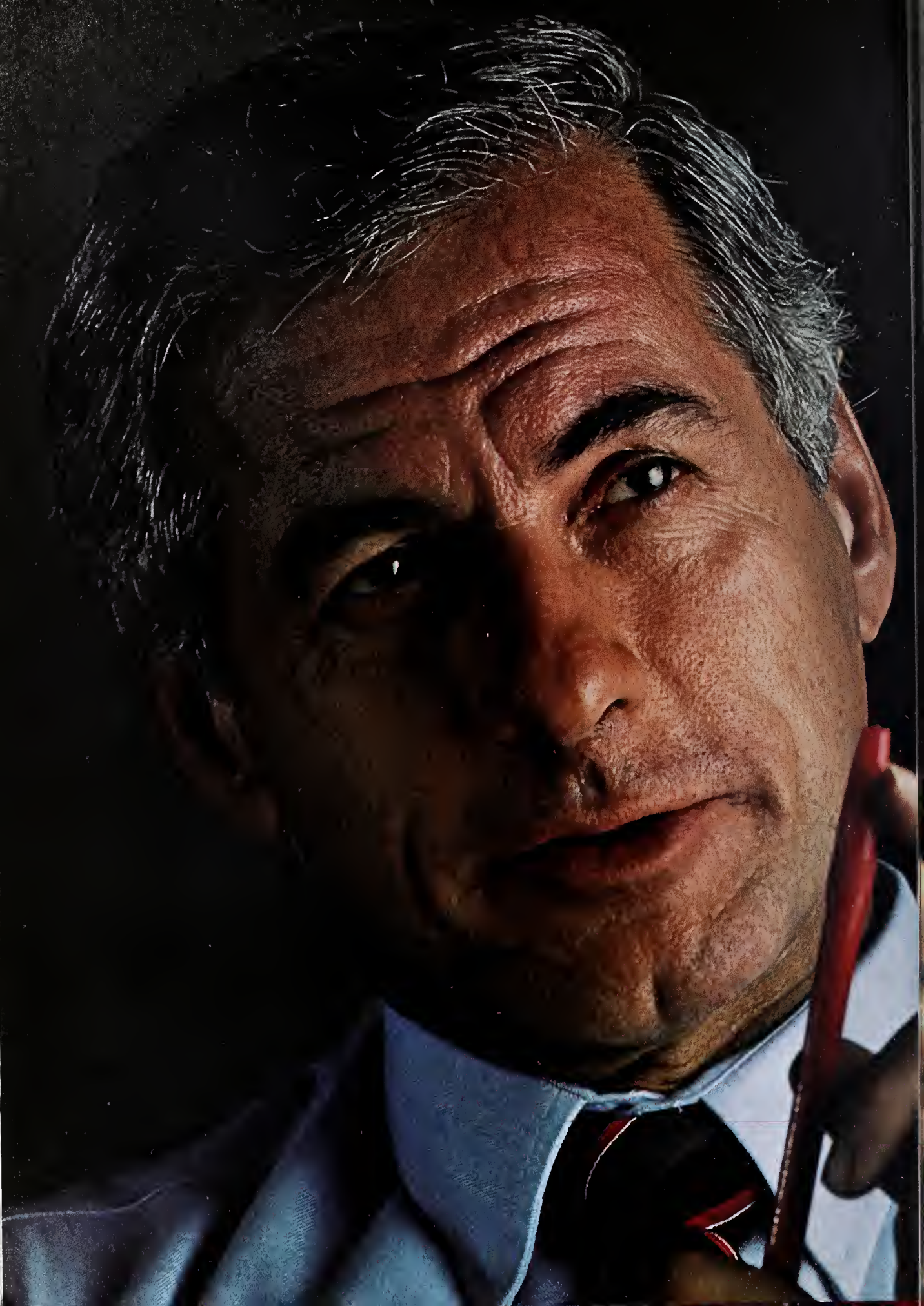
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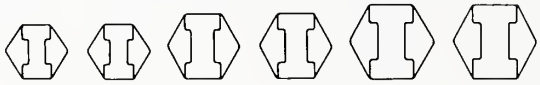
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL: In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC: Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing, at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetic).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml·hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL (propranolol hydrochloride) should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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Confidentiality of Peer Review Records

Physicians engaging in peer review activities are reminded that state law provides for confidentiality of peer review records. An exception, however, is that the record of proceedings to decide the issue of staff privileges would be open to the physician in question.

The peer review exemption from the legal discovery process stems from General Assembly passage of the Medical Studies Act. Passage was very strongly supported by the Illinois State Medical Society. This legislation was affirmed by the Illinois Supreme Court earlier this year *(Jenkins vs. Wu)* when it overturned a lower court decision granting the plaintiff in a malpractice case access to peer review records. ISMS had filed an *amicus curiae* (friend-of-the-court) brief which outlined for the Supreme Court the Society's objections to the lower court decision. The Medical Studies Act provides that:

> "All information, interviews, reports, statements, memoranda or other data of the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies, physician-owned inter-insurance exchanges and their agents, or committees of accredited hospitals or their medical staffs, including Patient Care Audit Committees, Medical Care Evaluation Committees, Utilization Review Committees, Credential Committees and Executive Committees, (but not the medical records pertaining to the patient), used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care, shall be privileged, strictly confidential and shall be used only for medical research, the evaluation and improvement of quality care, or granting, limiting or revoking staff privileges, except that in any hospital proceeding to decide upon a physician's staff privileges, or in any judicial review thereof, the claim of confidentiality shall not be invoked to deny such physician access to or use of data upon which such a decision was based."

The peer review exemption was challenged in a Cook County trial court when a professional liability suit plaintiff subpoenaed a hospital's medical review panel reports regarding patient care provided by a physician defendant. The lower court overruled hospital objections that such records were privileged under the law. The judge in the case declared that the Medical Studies Act violated state and federal equal protection clauses and constituted special legislation.

On appeal, the Illinois Supreme Court overturned the trial judge's ruling, saying that it recognized a distinction between a physician challenging a denial of hospital staff privileges and plaintiffs seeking records in a professional liability case. According to the court, the law protects due process rights of physicians by permitting physician access to review committee information in decisions regarding staff privileges, and denial of such information to professional liability plaintiffs "should have little impact on their ability to maintain their cause of action."

The court further held that the purpose of the law was not to facilitate the prosecution of malpractice cases but "to ensure the effectiveness of professional self-evaluation, by members of the medical profession in the interest of improving the quality of health care." Without protection of records, "physicians would be reluctant to sit on peer review committees and engage in frank evaluations of their colleagues," according to the court.

Similar peer review statutes have been under attack in other states, according to the American Medical Association. States in which court rulings have upheld peer review record protection include Arizona, California, Colorado, Connecticut, Nebraska, Washington and Wisconsin, the AMA reported. ◀

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JANUARY

Surgery

Specialty Review in Thoracic Surgery
For: MDs. Lecture, January 7-12, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $600.00. **Reg. Limit:** TBA. **Credit:** Category 1, 46 hours. **Contact:** Robert J. Baker, MD. **Phone:** 800-621-4649

Specialty Review in General Surgery, Part II
For: MDs. Lecture, January 29-February 8, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $750.00. **Reg. Limit:** TBA. **Credit:** Category 1, 100 hours. **Contact:** Robert J. Baker, MD. **Phone:** 800-621-4649

Cardiology

Modern Cardiology and Technology
For: Cardiologists, MDs. Lecture, January 16, 23 and 30, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, Illinois 60612. **Fee:** $100.00 **Reg. Limit:** 90. **Credit:** Category 1, TBA. **Contact:** Robert J. Baker, MD. **Phone:** 800-621-4649

Nutrition

A.S.P.E.N.'s Annual 9th Clinical Congress
For: MDs. 9th Clinical Congress, January 21-24, Miami Beach, Florida. **Sponsor:** The American Society of Parenteral and Enteral Nutrition, 1025 Vermont Ave., N.W., Washington, D.C. 20005. **Fee:** $120-250. **Reg. Limit:** None. **Credit:** Category 1, 25 hours. **Contact:** Donna M. Baudrau. **Phone:** 202-638-5881

Allergy

Impact on Health Maintenance Organizations on Allergy Practice-Present and Future
For: Allergists. Lecture, January 21, 8:00 pm, Holiday Inn, Chicago. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Highway, Mount Prospect, Illinois 60056. **Fee:** $15.00. **Reg. Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312-255-1024

Radiology

Update in Radiology
For: MDs. Symposium, January 10, 1:00-5:00 pm, Lincoln, Illinois. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee:** $45.00 **Reg. Limit:** None. **Credit:** Category 1, 4 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

General Medicine

Medical Seminar-at-Sea
For: MDs. Seminar, January 19-30, Caribbean Cruise. **Sponsor:** Southern Illinois University School of Medicine, PO Box 3926, Springfield, Illinois 62708. **Fee:** $500.00 **Reg. Limit:** None. **Credit:** Category 1, 48 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** 217-782-7711

Pathology

Hyperlipidemia
For: Pathologists. Symposium, January 14, 1985 at 7:00 pm., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, 645 S. Central Avenue, Chicago, 60644. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hrs. **Contact:** Marshall Short, MD. **Phone:** 312-626-4300.

FEBRUARY

Allergy

Regional Concept of Botany of Midwest
For: Allergists. Lecture and case presentations, February 17, Chicago. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 East Northwest Highway, Suite 101, Mount Prospect, 60056. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, 5 hrs. **Contact:** Diane K. Kubis. **Phone:** 312-255-1024.

General Medicine

Medical Seminar-at-Sea
For: MDs, Surgeons. Seminar, February 15-March 3, Panama Trans-Canal Cruise. **Sponsor:** Southern Illinois University School of Medicine, Post Office Box 3926, Springfield, 62708. **Fee:** $600.00 **Reg. Limit:** TBD. **Credit:** Category 1, 66 hrs. **Contact:** Charles Osborne, Ed. D., Assistant Dean for Continuing Medical Education. **Phone:** 217-782-7711.

Advances in Family Medicine
For: MDs. Lecture, February 11-15, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $500.00 **Reg. Limit:** 90. **Credit:** Category 1, 35 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Neurology

The Biologic Basis of Neurology and Psychiatry
For: Neurologists, Psychiatrists. Lecture, February 25-March 1, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $570.00 **Reg. Limit:** 90. **Credit:** Category 1, 42 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Pathology

The Pathologist's Roll as a Clinical Consultant in Laboratory Medicine
For: Pathologists. Lecture, February 11, Chicago. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 South Central Avenue, Chicago, 60644-9987. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hrs. **Contact:** Marshall H. Short, M.D. **Phone:** 312-626-4300, Ext. 5720.

Surgery

Review Course in Neurological Surgery
For: Neurosurgeons, Neurologists. Lecture, February 1-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $750.00 **Reg. Limit:** None. **Credit:** Category 1, 101 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, February 25-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $490.00. **Reg. Limit:** 15. **Credit:** Category 1, 16 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

MARCH

General Medicine

Medical Seminar-at-Sea
For: Physicians, Surgeons. Caribbean Cruise, March 3-11, 1985. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $400.00. **Reg. Limit:** None. **Credit:** Category 1, 36 hours; AAFP, 36 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711.

Medicine

Infectious Disease Symposium
For: Physicians, Surgeons, Staff. Symposium, March 29, 1985, 1:00-5:20 p.m., Pinckneyville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711.

Ophthalmology

Ophthalmology Current Concepts Seminar '85
For: Ophthalmologists. Lecturers, workshops, exhibits March 28-29, 1985 and optional March 30, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg, 610 Walnut Street, Madison, Wisconsin 53705. **Cosponsor:** University of Wisconsin-Madison, School of Medicine, Department of Ophthalmology. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBD; UW-Extension CEU's, TBD. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608-263-2856.

Psychiatry

Comprehensive Psychiatry Review Part II: The Psychiatric Interview
For: Psychiatrists. Course, March 8-10, 1985, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $375.00. **Reg. Limit:** None. **Credit:** Category 1, 17 hours. **Contact:** Mary Ann Dillon. **Phone** 312-962-1056.

Comprehensive Psychiatry Review Part I: Basic Considerations
For: Psychiatrists. Course, March 17-23, 1985, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $500.00. **Reg. Limit:** None. **Credit:** Category 1, 42 hours. **Contact:** Mary Ann Dillon. **Phone:** 313-962-1056.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The neurotransmitter substance, norepinephrine, is reduced in patients with Parkinson syndromes, which may delay reaction times and diminish intellectual functions. The metabolite of norepinephrine was studied in 39 patients with idiopathic Parkinson Syndrome and was found to correlate with intellectual dysfunction, rather than age, bradykinesia or dementia. (Stern, Y., *et al: Arch Neurol* 41:1086-89, 1984).

Patients with multiple sclerosis, temporal lobe epilepsy, and amyotrophic lateral sclerosis were evaluated for behavioral abnormalities between 1965 and 1978. The multiple sclerosis patients exhibited a significantly high incidence of depressed affective disorders (61.97%) whereas the amyotrophic lateral sclerosis patients showed only minimal psychiatric contacts (4.8%). The authors suggest possible causes of limbic area demyelination, genetic vulnerability, and selective monoamine metabolism alterations. (Schiffer, R., Babigian, H.: *Arch Neurol* 41:1067-69, 1984)

Continuity in health care provided to 776 men aged 55 and over by the same health care provider had a beneficial effect on patient satisfaction and resulted in fewer emergent hospital admissions and shorter hospital stays. These patients perceived their providers to be more knowledgeable, more thorough, and interested in patient education. (Wasson, J., *et al: JAMA* 252:17, 2413-17, 1984)

Short-term oral zinc supplementation had a marked beneficial effect in 22 patients with cirrhosis and chronic encephalopathy. Zinc acetate 200mg was administered three times daily and contrasted to placebos in stable alcoholic cirrhotic patients on a diet restricted to 40gms of protein per day. No adverse reactions were experienced. Zinc may improve the activities of enzymes involved in the metabolism of urea and ammonia in the liver or the muscles and thus reduce the toxicity of ammonia. (Reding, P., *et al: The Lancet* 8401:2, 493-5, 1984)

The increased production of thromboxanes in platelets of diabetic patients may be secondary to high blood glucose or lipid concentrations rather than vessel wall injury. The vessel wall endothelium may secrete less prostacycline because of long term stimulation or injury. The development of increased atherosclerosis and the increased incidence of thromboembolism may be due to hypersensitive platelets or vessel wall changes increasing platelet adhesions. Effective control of glucose levels in the blood may be the most useful means of ameliorating platelet abnormalities in the development of vascular disease in diabetics. (Mustard, J., Packham, M.: *N Engl J Med* 311:10, 665-6, 1984)

Cardiac mortality has been correlated with mean peak serum creatine kinase greater than 1,280 IU/liter, history of previous myocardial infarction, and ST segment depression at rest. The only exercise variable that correlated with cardiac mortality was poor exercise endurance of less than three minutes. The variables obtained from predischarge treadmill tests thus may not warrant this test procedure. (Williams, W., *et al: JACC* 4:3, 477-86 1984)

A prospective analysis of the prehospital phase in 110 patients revealed that those with initial hypotension had a higher mortality than those with hypertension or normotension. Ten patients with initial bradycardia without hypotension had zero mortality. Hemodynamic stabilization during hospital transport may thus be crucial. Twenty one percent of the 110 cases died and 60% experienced at least one in-hospital complication. (Pressley, J. *et al: JACC* 4:3, 487-92, 1984)

Approximately 75% of women with idiopathic anorectal incontinence showed denervation of the pelvic floor muscles, slowed conduction in the pudendal and pelvic branches of the sacral plexus. Fecal and urinary incontinence thus may be secondary to nerve damage rather than sphincter injury or muscle stretching. The major predisposing factors are multiparity, forceps assisted delivery, prolonged labor, or history of pelvic floor injury. The neurologic effect in multiparity may be cummulative. (Snooks, S., *et al: The Lancet* 8402:2, 546-50, 1984)

Competitive long distance running of 10-42.2km induces gastrointestinal blood loss and may contribute to iron deficiency syndromes. Blood and stool samples collected from 24 runners before and after a race showed a lower blood hemoglobin and hematocrit than in controls. Fecal hemoglobin was noted in 20 of the 24 runners. (Stewart, J., *et al: Ann Intern Med.* 100:843-5, 1984)

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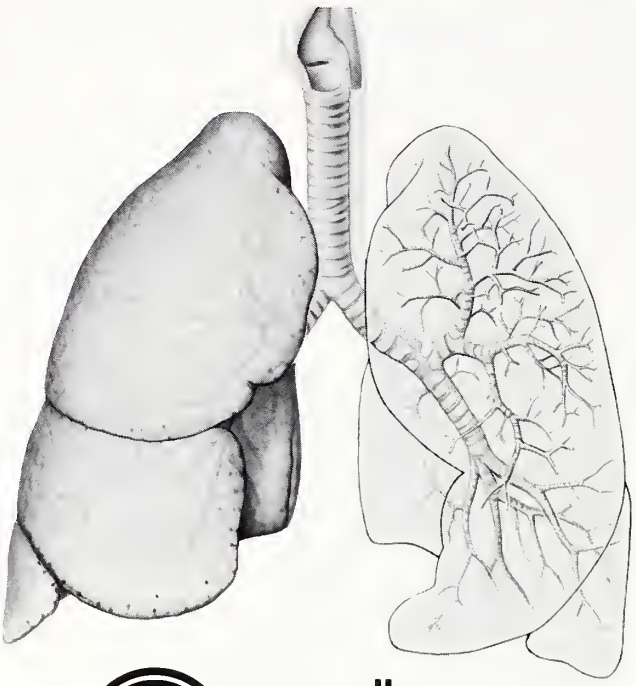
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Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor* (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

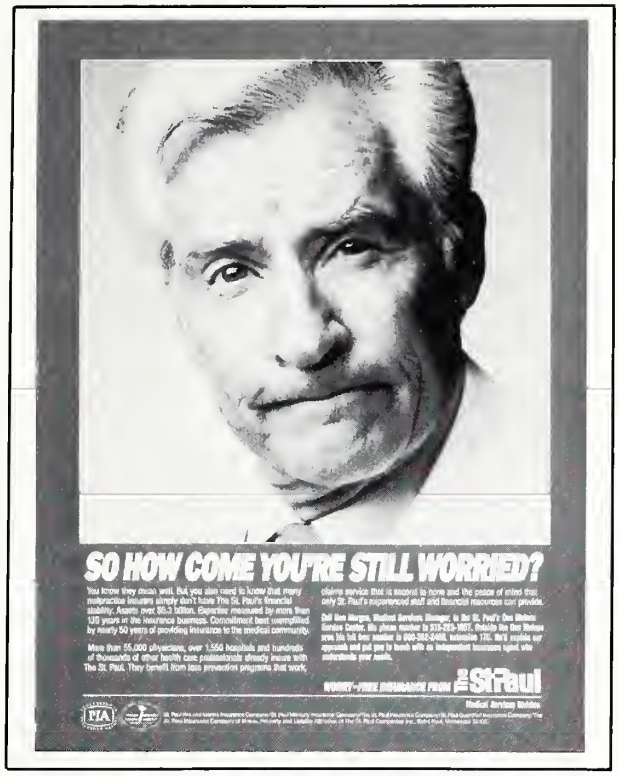
Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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An Open Letter From the AAMA Physician Advisors

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This letter is to acquaint you with the benefits available to your office personnel through the American Association of Medical Assistants. For those of us who have enjoyed a long relationship with this association, the cost-savings provided by a higher level of professional competence among our assistants have far out-stripped the modest costs of supporting their membership.

The AAMA is a professional association, formed 31 years ago. It is a tri-level organization for individuals who work under the supervision of physicians, in the physician's office, hospitals or other facilities, performing administrative and/or clinical duties. Its national, state and local chapters are doorways to professionally directed programs, designed to improve the abilities of your assistants in the delivery of health care. The AAMA is a nonprofit organization. It is not, nor shall it ever become, a trade union or collective bargaining agency. The AAMA is generously endorsed by the AMA and the ISMS and we fully endorse the programs and functions of the AAMA.

A medical assistant is defined as anyone who works under the supervision of a physician licensed to practice medicine, and AAMA membership is open to receptionists, secretaries, bookkeepers, nurses, technicians or any person assisting within your range of supervision.

Continuing education is the main objective of AAMA. There is ready access to state and nationally sponsored programs, including self-study courses and advisory help. Education classes are held regularly, and lectures are conducted by physicians and other professionals supporting the practice of medicine.

Group life, medical, long-term disability and professional liability insurance is available to members at reduced premiums. AAMA also encourages advancement of medical assistants by offering a Certification Examination designed to recognize professional competency.

There is a local chapter of AAMA near you that meets monthly, usually in the evening. At these meetings medical assistants learn new capabilities and enjoy the fellowship of their co-workers in the community.

Dues currently are $66.00 for state and national. Chapter dues vary from $5.00 to $10.00. Dues are payable yearly on January 1. The dues include membership on the county (chapter), state and national levels and state and national educational periodicals.

In supporting the AAMA, by enrolling your medical assistant in the local chapter, you will be supporting your own practice of medicine in a highly professional manner.

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Further information about the Illinois Society, AAMA, may be obtained by contacting one of the officers: Anna Cannon, president, 7443 S. Luella, Chicago IL 60649; Betty J. Kronemeyer, CMA, immediate past president, 809 N. 10th, Mascoutah IL 62258; Ehlma Garcia, CMA-EMT, president-elect, 6134 S. Tripp, Chicago IL 60629; Cheryl Hutchison, CMA, first vice president, 53 Lockhaven, Granite City IL 62040; or Betty Jean Meier, second vice president, 2812 Barber Green Road, DeKalb IL 60115.

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Additional MRI information on page 416

IMJ

Illinois Medical Journal
Illinois State Medical Society

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In Children and Adolescents

Emotional Responses to Medical Illness

By Marjorie Forman, M.D./Maywood

Children and adolescents have specific, age appropriate, emotional responses to their medical and surgical illnesses. These are based upon the cognitive and psychological stage of the child's development. Examples, with a psychological explanation, are delineated for each age group.

Practical and supportive measures are outlined which can reduce or prevent the emotional trauma of medical and surgical illness and foster a continuing normal development in the child. In those instances of severe (chronic) illness or a dying child, specific therapeutic interventions are also suggested.

Infants, children and adolescents are aware of their bodily pain and suffering and respond to it both non-verbally and verbally. Sickness affects not only their feelings but also their physical and emotional functioning and development. Children also are affected both by the specifics of their medical and surgical treatment and by how the family and medical personnel respond to them when they are ill. Observant, sensitive parents, physicians, and other care-taking professionals may be aware of the impact of sickness upon children and adolescents. However, adults who have little close contact with youngsters rarely anticipate a child's emotional responses to sickness for two valid reasons.

First, adults seldom remember much of their own emotionally laden experiences, particularly those occurring before age six years. This is due to the normal phenomenon of repression or blocking of past negative memories. Second, the adult, when a child, understood and interpreted experiences in the emotional and intellectual framework consistent with that earlier stage of development, always different cognitively from adult perception.

Interferences with normal development, such as a sickness, have been termed trauma. Traumas may be handled well by a child in supportive circumstances, or he or she may develop immediate behavioral or emotional symptoms. There may be latent trauma that only becomes apparent during future physical, home, or school stress. Not every illness or other unhappy experience is a trauma. However, with sufficient stress (severity, duration or vulnerability) any individual, adult or child, can be overwhelmed. Thus dosage or degree is one important consideration, as is the repetition and/or the duration of the stress.

The innate personality of each child with strengths and weaknesses, such as intellect, talents, motor and verbal skills, are additional variables is assessing stress. So, too, are the strengths and weaknesses of each parent and the home realities.

An extremely significant factor influencing the degree of trauma due to sickness is the age at which the child becomes ill. What can be traumatic at one age or stage of development may be a growth experience for a child who has reached a higher level of maturation.

Generally, the more serious the illness, at any age, the more likely the experience will be a trauma. Chronic illnesses and those illnesses requiring repeated hospitalizations, separation from family, intrusive procedures (including surgery), restraint of movement (splints, etc.) or a marked change in the child's normal routine may be traumatic. Acute severe, or long-term (even lowgrade) chronic illnesses may disturb the normal emotional and behavioral equilibrium of the growing child and may also have long-term emotional consequences.

There is a remarkable individual difference in each child's sensitiveness to bodily pain. What is agonizing to one child may be negligible to another. What is different is not the actual bodily experience of pain, but the intellectual understanding

and psychological meaning of the pain.[1] Younger children generally believe that all pain comes from outside influences. Whether they actually hurt or not, children misperceive surgical and medical procedures and the aches and pains of infection and fever as punishment for real or imagined transgressions or as a life threat. An adolescent is better able to understand the source of symptoms and the cause of the pain due to actual sickness and separate that illness pain from the nuisance pain associated with necessary tests and treatment.

The greater the child's anxiety and that of the child's family and caretaking personnel, the more likely that the sickness, mild or not, may take on traumatic proportions.

This may occur, for example, when mononucleosis is feared to be leukemia and this concern is verbalized in the child's presence. In addition to normal anxiety, which is always present to some degree, children and adolescents respond emotionally in two general ways. On the one hand, the child may be quietly angry, or openly enraged, and want revenge. He or she may behave aggressively in the doctor's office or hospital. On the other hand, he or she may be very quiet, feel guilty, depressed, withdrawn and submissive. Blumberg[2] believes that anger and acting-out behaviors are forerunners to and defenses against depression and despair, a "last-ditch" stand so to speak. Anger and acting-out behavior (not excessive or prolonged) may be important mechanisms of self-assertion and manifestations of ego strength. Aggressive behaviors may be healthier than withdrawal because they also defend against the regression that commonly occurs during illness.

Unfortunately, the angry, uncooperative, demanding child is generally viewed as a bad patient. His or her behavior is rarely appreciated or understood. Adults, family or staff may respond with scoldings or punishment. Actually, protest behavior in a sick child is healthier and more adaptive than the passivity, compliance and absence of demands so valued in the "ideal patient." Passivity or compliance often indicates underlying despair and detachment that may be associated with a reactive depression in the sick child or adolescent. Not every quiet child patient is depressed. Only direct explicit questioning will reveal feelings of despondency, hopelessness, private crying or death wishes.

Prevention of Severe Emotional Trauma

There is no question that the medical or surgical treatment of the medically sick child is of significant, and at times, of primary and lifesaving importance. However, the disease or injury exists in a small person . . . a child who has a body, a mind, and feelings, but with limited understanding of detail, context, time and outcome.

Under Three Years

When the sick child requires hospitalization, additional stresses such as the anxiety of separation from the family compound the trauma of the sickness.[3] Separations from parents, particularly under age three years, can be devastating. If hospitalization is essential during the first three years of life, parent rooming-in or long daily visits can and should be arranged. Visits by other persons important to the child are helpful, as are the child's special possessions and "lovies." One nurse per shift should minister to all the patient's needs and the same nurse should be assigned to the same infant or child during every shift that nurse works. In those difficult situations where family cannot visit consistently, a regular phone call can be set up. Also, a daily "surrogate parent or grandparent" through the hospital's volunteer services can be arranged by a physician order and may be invaluable.

Three to Six Year Olds

Because of the three to six year old child's newly developing, and thus vulnerable, sense of body integrity and boundaries, only essential surgical procedures should be performed at these ages. During these years, the child views surgery as a life-threatening attack. What kind of surgical procedures, how serious or minor the operation, or upon what portion of the body it is performed, makes little difference to the child. At best mutilation or castration is feared and, at worst, annihilation.[4]

Sustained restraining techniques are now known to have serious or long term sequelae.[5] Tying a child's limbs and body down for anesthesia, phlebotomy or various tubes should be avoided as much as possible. Firm, gentle, personal holding with verbal reassurance is preferable. In orthopedic injuries requiring casting, mobilization should begin at the earliest possible time. Once the imposed restraints are removed, children will often exhibit temporary foul language, temper tantrums, irritability or restlessness. Bed restriction at home during sickness is rarely recommended today. Generally the child's available energy during the sickness effectively monitors an appropriate level of activity.

There are few parents who do not change their own attitude toward their sick child to some extent. Some parents who are afraid of overindulging and spoiling their child leave him or her very much alone. The majority of parents adopt the opposite attitude, and love and fondle the sick child more than at any other time. Because of the mother's anxiety about the child's health, all discipline may be stopped, good behavior is not expected and the child's every wish is indulged. The consequence of this well-meaning but ill-advised approach can be a family later and often permanently victimized by a "tyrant" child.

A mother's anxiety and preoccupation with her child's body may lead to forced feedings or toilet-ings. She may find herself deceiving her child about upcoming physician visits, treatments, or separations in a manner very uncharacteristic for her. These alterations from a mother's usual comfortable way of relating to her child, may cause confusion and unnecessary additional anxiety for the child during the trauma of illness. A temporary arrangement of mother sleeping with a sick child may in some cases become permanent and destroy the marital relationship. The physician should inquire and discourage such overprotection.

As a general principle, whenever

there is time beforehand for a physician to discuss with both parents and the child what will be done during the course of a sickness, it should be honestly done with simple, circumscribed discussions at the child's level of comprehension. Children should be invited to ask questions although they frequently may not. An astute parent can often observe their child "playing out" the issues with a puppy, a sibling or a toy. This rehearsing is healthy. In the arena of play the dialogue may continue by using a toy or drawing as a "third person." The parent may observe and repeat this at home. If preparatory discussions are begun too far in advance of a future procedure they may add to the child's anxiety. A week or less is usually sufficient. The pre-schooler and early latency-aged child has a poorly developed sense of time. The child under two years cannot yet think in symbolic terms (a hospital means a building with many rooms, for example). Thus, the preparatory information may not be of use to anticipate future events. Reassurance "I will be with you" is the more useful approach. However, when a known future physical or psychologically painful event is discussed ahead of time, it does alert the child and does not damage the very young child's sense of basic trust. Some pediatric nursing supervisors even advocate that a nurse awaken a newborn and talk to the infant briefly in a serious but soft voice before an injection or some other unpleasant violation is performed.

In prolonged or severe illnesses some regression and loss of a child's recently acquired psychological and physiological milestones, such as toileting, talking and dressing oneself, will occur. The child should not be shamed or punished but reassured and encouraged to regain these milestones as his or her health improves: "Too bad you soiled, but when the medicine works the diarrhea will stop and you will be clean and controlled again."

Six to Eleven Year Olds

The six to eleven year old begins to be less dependent upon family and more invested in school and neighborhood peers. This so called "latency age" is important and the child, as soon as physically able, should return to school and activities within the limits of comfort; after an illness, school refusal or school phobia may begin. The most effective treatment is to insist that the child go to school on the very first day of school refusal and notify the school authorities that the child should not be sent home that day for various "aches and pains." The longer a child is allowed to refuse school the more tenacious a school phobia becomes. Doctor's excuse slips may be misused and may only aggravate a problem which, if persistent, may needlessly lead to psychiatric inpatient management.

Teenagers

Sick adolescents should be encouraged and required, with supervision, to care for themselves physically, to take their medications and participate in "appropriate" daily social or interpersonal ward or home activities. Not doing this increases the sick adolescent's sense of being weak, helpless, dependent and different. No distress is greater to an active, energetic adolescent than to become a passive patient.

Therapeutic Intervention

In severe or prolonged (chronic) illnesses, infants, children, and adolescents often develop persistent anxiety, acting out, or depression accompanied by regressive behaviors. They may function at a level much younger than they had attained just prior to the illness. Depending upon the condition, when infants, children and adolescents do not return to their highest level of pre-illness functioning within 3-12 weeks after recovery, then play therapy, psychotherapy or family therapy with a child therapist is indicated. The earlier the intervention, the easier these problems are to treat. Such early intervention prevents anxiety, acting out, depression and regressive (immature) behaviors from becoming an entrenched way of life.

Occasionally, as in the dying child patient, anxiety in important adults around the child and subsequently within the child, is so pervasive and overwhelming that the child may feel on the edge of panic. In these circumstances it may be appropriate to give medication to the dying child that will reduce both the level of pain and of anxiety to make him or her more physically and emotionally comfortable. However, this must be titrated. It is of no advantage to create a stage of semiconsciousness. For all ages, elixer of diphenhydramine in appropriate dosage is effective and does not cause respiratory depression. Benzodiazapines should generally be avoided. In terminal illness, those psychotropics (such as hydroxyzine pamoate or serazepam) which do not cause a "high" (agitation) or a respiratory depression will help make the dying child patient more comfortable, while still able to relate fully to loved ones in the final days. Although the parents may refuse, they should be offered 50mg diphenhydramine at bed time for very mild night sedation, while allowing them to be alert if called to their child's bedside before morning. ◀

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Primary Common Bile Duct Stones and Recurrent Pancreatitis

By Nalin M. Patel, M.D./Champaign

A patient had suffered from intermittent attacks of acute pancreatitis for fifteen years. During each episode liver enzymes, gall bladder Xrays and ultrasound were normal. An intravenous cholangiogram was performed. It revealed a dilated common bile duct with two oblong stones floating within it. This case is described and the literature reviewed.

A 43 year old female was admitted with mid-abdominal pain, nausea and vomiting. She denied taking any alcohol or medication. There was no history of diabetes mellitus or hyperlipidemia. Physical examination showed a blood pressure of 140/70 and a pulse of 84/min. There was no scleral icterus. Liver size was normal. Slight epigastric tenderness was observed. Rectal examination was unremarkable and stool was negative for occult blood. Hemoglobin was 15gm% and hematocrit 47%. Total leucocyte number was normal with a normal differential count. S.M.A. 12/60 was normal. Serum amylase was 340 units (normal 50-200) and a two hour urine amylase was 496 units (normal 38-318). Gall bladder Xrays were normal. Ultrasound of liver, pancreas and gall bladder was normal.

An intravenous cholangiogram showed two oblong stones within a dilated common bile duct. Endoscopic retrograde cholangiopancreatogram was not performed because of the acute pancreatitis. Two weeks later, the patient underwent a cholecystectomy, which revealed a normal gall bladder, and upon exploration of the biliary tree, three oblong, soft stones were recovered. The patient has felt well since surgery and has had no further attacks of pancreatitis.

Discussion

Gall stones are known to cause pancreatitis.[1] In one study, 34 of 36 patients with pancreatitis showed gall stones in their feces.[2] Madden[3] claims that primary bile duct stones are more common than secondary bile duct stones. Others, such as the Johns Hopkins group[3] believe that the true incidence is much less than that claimed by Madden. Common bile duct stones may cause stricture of the duct and enteric fistula. Tytgat, *et al.*,[4] found 11 common bile duct strictures and 13 enteric fistulae in their series of 100 patients with choledocholethiasis.

Ultrasound is useful in the detection of gall stones,[6] but it is not quite as useful for common bile duct stones. Gross, *et al.*,[7] studied 90 patients with ultrasound and endoscopic retrograde cholangiopancreatogram (ERCP). The ultrasound was diagnostic in 25% of patients with choledocholethiasis. However, the accuracy of a negative diagnosis was 73%: It appears that common bile duct stones are not reliably excluded by a negative ultrasound examination.

Cronan, *et al.*,[8] prospectively studied 87 patients who had biliary symptomatology with ultrasonograph prior to surgery. A total of 13% of the common bile duct stones found at surgery were detected by the ultrasound. Of 87 patients, 31 (36%) had non-dilated ducts both at ultrasonography and at surgery.

Non-dilated common bile ducts may also have stones.[9] ERCP was contraindicated in our patient on account of the acute pancreatitis. In those patients who do not have acute pancreatitis, ERCP is a useful diagnostic test for choledocholethiasis. Frey, *et al.*,[10] studied 72 patients with both ERCP and operative common duct exploration and found ERCP to have a sensitivity of 90.4%, a specificity of 98% and an accuracy of 95.8%.

In the evaluation of choledocholethiasis, a "skinny" needle per-

cutaneous-transhepatic cholangiogram (PTC) is a valuable and safe diagnostic tool. Until the advent of ERCP, PTC was considered the essential tool for radiologic diagnosis in suspected biliary obstruction.[11] In the presence of cholestasis, intravenous cholangiography (IVC) is generally unsuccessful and therefore inferior to ERPC and PTC. Furthermore, it is contraindicated in patients who are allergic to intravenous dye and it may cause complications such as anaphylactic shock and pruritic rash. In our patient ERCP was contraindicated and since she refused PTC we had to do an IVC. Patients suspected to have common bile duct stones ought to have ERCP or PTC if ultrasound and IVC are inconclusive.

Operative cholangiography is another way of identifying common bile duct stones. Lane, *et al.*,[12] in their prospective comparison between operative cholangiography and operative choledochosonography, found the latter to be easier and quicker to perform. In their series of 100 patients, they found operative ultrasonography to have a sensitivity of 96% and specificity of 93% as compared to a sensitivity of 96% and specificity of 96% with operative cholangiography. This suggests that operative ultrasonography is superior to the conventional ultrasonography.

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An Association with Birth Control Pills

Moyamoya

By Winston Sequeira, M.D., Mohammad Naseem, M.D., and D. Alan Bouffard, M.D., Chicago

Moyamoya is an angiogram finding of severely narrowed or occluded internal carotid arteries in the distal intracranial portion with a telengiectatic rete of collateral vessels at the base of the brain. The posterior circulation may be involved, although it is usually intact. The term was first used by Suzuki[1] in 1969, although patients with similar occlusive disease of the internal carotid artery were described in 1961 by Nomura and Takeuchi.[2,3]

This is a case report of moyamoya associated with the use of birth control pills and antinuclear antibody in high titers.



Figure 1—
The right carotid arteriogram Shows complete occlusion of the internal carotid artery (middle arrow) distal to the posterior communicating artery. The anterior cerebral artery is filled via collaterals (anterior and posterior arrows).

A 16-year-old black female presented to the hospital with a chief complaint of intermittent right arm and leg weakness for three weeks. She described an unusual sensation of "water running through her right arm and leg." This sensation was constant and resolved over 2-3 days. She then began to experience intermittent twitching of the right side of the face, arm and leg. The twitching was followed by weakness and clumsiness of the right arm and leg, slow speech, numbness of the fingers of the right hand, and blurred vision lasting approximately five minutes. These episodes occurred 3-4 times a day. A history of mild right frontal parietal headaches beginning three weeks prior to admission, which resolved in two weeks, was also reported.

Patient reported a history of hay fever, stating that she had used chlorpheniramine for "sinus." She was allergic to walnuts and had required an E.R. visit three days prior to her admission. At that time, she had been treated with diphenhydramine and epinephrine. There was no past hospitalization. She denied history of hypertension, TB, arthritis, photosensitivity, skin rash, Raynaud's, alopecia, or chest pain suggestive of pleuritic or pericardial disease. Patient had taken birth control pills since age 13.

Her physical examination was normal. This covered blood pressure, a detailed neurological evaluation, auscultation for carotid bruits, heart murmurs and a fundiscopic examination. CBC, platelets, prothrombin time, partial thromboplastin time, glucose, BUN, electrolytes, albumin, globulin, and gamma globulin were normal. ESR (Wintrobe) was 22mm/hour, ANA 1:1280 homogenous, C3 93mg% (normal 85 to 120), rheumatoid factor 1:80, DsDNA antibodies negative; urine analysis 1+ proteinuria, 24 hour urine for protein 78 mg. CAT scan, with and without enhancement, was normal. Electroencephalogram revealed mild right temporal slow activity on an otherwise normal background. A retrograde femoral aortic arch and cere-



Figure 2—
The left carotid arteriogram
The lateral view in delayed arterial phase shows identical findings compared to the right side.

bral angiogram were performed. The right carotid arteriogram (Figure 1) showed complete occlusion of the middle cerebral artery distal to the posterior communicating artery. The anterior cerebral artery was filled via collaterals (Figure 2). The left carotid arteriogram in the lateral view, in the delayed arterial phase, showed identical findings compared to the right side. The right vertebral arteriogram (Figures 3A, B) in the midarterial phase showed that many of the branches of the anterior circulation were filled via collaterals.

The patient received no specific therapy. She was advised against oral contraceptives and was placed on sodium phenobarbitol 90mg at bedtime. Follow up for a period of nine months revealed no recurrence of neurologic symptoms. Physical examination remained normal and repeat electroencephalogram eight months after discharge was normal when awake and in light sleep.

Discussion

Moyamoya has been described in a variety of diseases, including neurocutaneous syndromes,[4,5] bacterial meningitis, polyarteritis nodosum, head trauma, tuberculosis,[5,6] sickle cell anemia,[7,8] and Fanconi syndrome.[9]

The condition is most frequently found in infants and adolescent females of Japanese origin, although there are many reports of similar cases in the non-Japanese. The syndrome may be found in identical twins[10] and in individuals who have been associated with vascular abnormalities like Fanconi syndrome.[9] It may develop in patients with sickle cell disease, and has been noticed on subsequent angiograms done for repeated cerebrovascular accidents.[7,8] In an extensive review of the literature by Nishimoto and Takeuchi,[11] the most common symptom for patients under 16 was weakness, but convulsions, headaches, and mental retardation were not unusual. In older patients, subarachnoid hemorrhage is a common clinical feature.[12,13]

The most prominent manifestation in our patients was simple partial motor seizures. There was an associated high titer of antinuclear antibodies. This association of antinuclear antibodies and moyamoya has not been previously described. Lupus cerebritis with seizures most often occurs along with clinical and laboratory evidence of disease activity. In 1-4% of cases, however, it may be the initial manifestation of the disease.[14] The diagnosis of lupus cerebritis is based on the exclusion of other diseases in a patient with active systemic disease because of the absence of specific diagnostic tests. Although the arteriographic and clinical presentation in this patient may be a consequence of restricted lupus, this is unproven.

Follow up for nine months failed to uncover other manifestations of systemic lupus erythematosus. It is also possible that the entire clinical picture could be explained on the basis of oral contraceptive use since oral contraceptives have been associated with an increased incidence of thromboembolism,[15] stroke and a positive ANA.[14] There is a single previous report[16] of moyamoya associated with oral contraceptive use raising the possibility of more than a chance occurrence. Reports of additional similar cases may help clarify the issue. ◀

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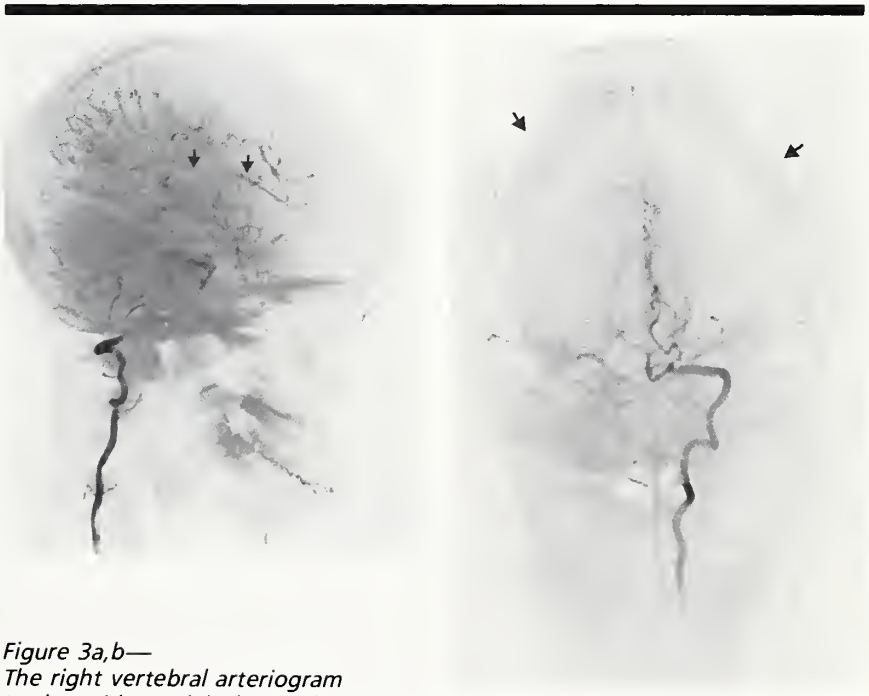


Figure 3a,b—
The right vertebral arteriogram
In the mid arterial phase: shows that many of the branches of the anterior circulation are filled via collaterals (arrows).

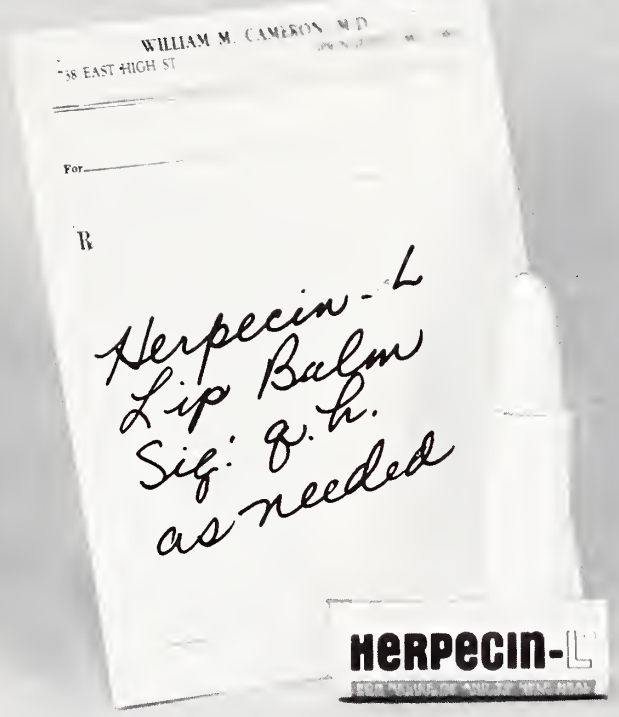
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Time Study of an Emergency Room

Identification of Sources of Patient Delay

By Paul S. Heckerling, M.D. Chicago

We studied 2,067 patients seen in our emergency services over a five week period to quantify factors contributing to long patient visit times. Forty-one percent of our patients required over 2½ hours, and 21% over 3½ hours, to complete the visit. Prolonged waiting times to see a physician, to obtain results of laboratory and radiographic studies, and to complete admission procedures, correlated significantly with long patient visits. Time flow studies can identify factors contributing to lengthy emergency room stays.

The number of emergency room patient visits has increased dramatically over the last two decades, from 42 million in 1960 to 81.3 million in 1979.[1] In addition, emergency rooms have increasingly been called upon to provide non-urgent ambulatory care, as well as critical care, to large urban populations.[2-4] Because of this growing volume of patients, expeditious patient flow through the emergency services has assumed greater importance. Relatively few studies have addressed the problem of time spent by patients in various phases of emergency room care or documented sources of delay in patient flow.[5-8]

This report describes a time flow study of our emergency services and examines those factors that contribute to long patient delays.

Background

Our facility is an 873 bed voluntary hospital located in the metropolitan Chicago area. The emergency services received a total of 33,838 patient visits for the 1981 fiscal year, of which 23,603 were adult and 10,235 were pediatric cases.

The emergency services is divided into four patient care areas: medicine, where patients with medical illnesses judged to be urgent are seen; surgery, where patients with a wide spectrum of surgical problems ranging from urgent to non-urgent are seen; acute care, where patients with medical problems judged to be non-urgent are seen; and pediatrics, where all patients seventeen years of age or younger, regardless of the nature and urgency of their problem, are seen.

Methods

All patients seen in the emergency services over a five week period were included in the study. For each patient, the following times were recorded:

(a) Time patient was registered into the emergency services, which was the same as the time patient was triaged by a nurse.
(b) Time patient was first seen by a physician.
(c) Time(s) laboratory tests (blood counts, chemistries, urinalyses) were sent and results were received.
(d) Time(s) radiographic studies were ordered and results were received.
(e) Time decision was made to admit the patient to the hospital or to discharge the patient from the emergency services.
(f) Time patient left the emergency room.

For purposes of analysis, patients were subdivided on the basis of total time spent in the emergency services into "short-stay patients"

Table 1
Length of Emergency Room Stay: By Patient Type

Patient Type*	Patients Completing Emergency Room Visit in <2.5 hrs.	<3.5 hrs.	<5.0 hrs.
All patients (2,067)	58%	79%	93%
Medicine patients (392)	41%	66%	87%
Surgical patients (361)	56%	79%	92%
Acute Care patients (690)	60%	79%	93%
Pediatric patients (614)	69%	96%	96%

*() = number of patients

(length of stay less than one hour), "average-stay patients" (length of stay greater than one hour but less than three and one-half hours) and "long-stay patients" (length of stay greater than three and one-half hours). Statistical significance was determined by chi-square analysis.

Total Time Spent in the Emergency Room

A total of 3,039 patients were seen in the emergency services during the study period; data sufficient for analysis was obtained on 2,067 (68%). Results on total length of stay in the emergency room are shown in Table 1. Forty-two percent of the patients required more than 2.5 hours and 21% more than 3.5 hours, to complete the visit. Urgent medical patients required significantly longer to complete their visit than did non-urgent medical patients; 60% of non-urgent medical patients, but only 41% of urgent patients finished the visit within 2.5 hours ($p < .001$).

Table 2
Waiting Time to See a Physician By Patient Type

Patient Type	Patients Seen by a Physician Within 15 mins.	30 mins.	60 mins.	90 mins.
All patients (1,763)	33%	60%	84%	92%
Medicine patients (318)	51%	78%	91%	95%
Surgical patients (304)	39%	68%	89%	95%
Acute Care patients (609)	16%	43%	76%	90%
Pediatric patients (527)	38%	65%	84%	92%

*() = number of patients

Waiting Time to See a Physician

Data concerning time from entry into the emergency room until initial contact with a physician was obtained on 1,763 patients (58%) (Table 2). Sixty percent of patients were seen within 30 minutes; 84% were seen within one hour. Urgent medical patients were seen significantly more frequently than non-urgent medical patients within 15 minutes (51% vs. 16%) ($p < .001$) and within 30 minutes (78% vs. 43%) ($p < .001$). When subdivided by total time spent in the emergency services, "short-stay patients" were seen significantly more frequently within 15 minutes (53% vs. 28% and 31%) ($p < .001$) and within 30 minutes (86% vs. 55% and 55%) ($p < .001$), than were "average-stay" and "long-stay" patients (Table 3). The difference between "average-stay" and "long-stay" patients in time to be seen by a physician was not significant.

Turnaround Time for Laboratory Tests and Radiographic Studies

Results of the turnaround times for laboratory tests and radiographic studies are shown in Table 4. Results of only 43% of blood counts, 29% of urinalyses and 17% of chemistries were available within one hour. At 1.5 hours, almost one-fourth of the blood counts, three-eighths of the urinalyses, and well over half the chemistries were still not available. The turnaround time on radiographic data was somewhat better, with 62% and 83% of Xray results available at one hour and one and one-half hours, respectively. Smaller numbers of patients on whom data was obtained precluded subclassifying these populations by urgency of the medical problem or total length of emergency room stay.

Table 3
Waiting Time to See a Physician By Length of Emergency Room Stay

Patient Type*	Patients Seen by a Physician Within: 15 mins.	30 mins.	60 mins.
Short-stay patients (210)	53%	86%	—
Average-stay patients (886)	28%	55%	81%
Long-stay patients (299)	31%	55%	77%

*() = number of patients

Table 4
Time to Obtain Laboratory Results

Laboratory/ Radiographic Studies*	Laboratory Results Available Within: 1 hour	1.5 hours	2.5 hours
Complete blood counts (258)	43%	78%	95%
Chemistries (217)	17%	48%	83%
Urinalyses (90)	29%	62%	89%
X-rays (583)	62%	83%	97%

*() = number of laboratory tests

Table 5
Admission Times By Patient Type

Patient Type*	Patient Transported from the Emergency Room Within: 1.5 hours	2.0 hours	3.0 hours
All patients (371)	51%	72%	88%
Medicine patients (169)	53%	72%	87%
Surgical patients (61)	37%	67%	85%
Acute Care patients (80)	54%	71%	91%
Pediatric patients (59)	54%	75%	90%

*() = number of patients

Table 6
Admission Times By Length of Emergency Room Stay

Patient Type*	Patient Transported from the Emergency Room Within: 1.5 hours	2.0 hours	3.0 hours
Short-stay patients	—	—	—
Average-stay patients (173)	54%	82%	97%
Long-stay patients (179)	43%	59%	78%

*() = number of patients

Time to Admission

Eighteen percent of emergency room patients were admitted to the hospital. Table 5 presents the data on admission times. Approximately 50% of the patients required greater than 1.5 hours, and 25% greater than two hours, to be transported from the emergency room to a hospital bed following a decision to admit. Significantly fewer "long-stay" than "average-stay" patients were admitted within 1.5 hours (43% vs. 54%) ($p < .05$), within two hours (59% vs. 82%) ($p < .001$) and within three hours (78% vs. 97%) ($p < .001$) (Table 6).

Discussion

The major finding of this study is that a significant fraction of our patients required long times to complete their emergency room visit; 58% and 79% completed the visit within 2.5 and 3.5 hours, respectively. These times are somewhat in excess of those reported in the literature. For example, a study from the New York Hospital (Goss, *et al.*) reported a median emergency room visit time of 93 minutes, with 63% and 82% of patients completing the visit within two and three hours, respectively.[6] Reiber found that at a California hospital, 66% of patients completed the visit within two hours.[5] Fineberg used a queueing network model to study patient flow and reported that 60% and 79% of patients finished their emergency visit within two and three hours respectively.[8]

We found that 60% of all patients and 78% of medically urgent patients were seen by a physician within 30 minutes of arrival in the emergency room. Time to see a physician correlated with total visit time. Over 85% of patients whose length of stay was less than one hour were seen within 30 minutes, but only 55% of those whose length of stay was greater than one hour were seen within the first half-hour. Cue, *et al.*,[7] in a survey of several Washington, D.C. hospitals, found that the average waiting time to see the physician was 47 minutes in urban emergency departments and 17 minutes in small community departments. They also found a linear correlation between average total visit time and average time to see a physician. Other studies have documented that 58%[6] and 55%[5] of patients are seen within 30 minutes of their arrival in the emergency services, results comparable to ours.

The turnaround times for laboratory tests and radiographic studies were often prolonged beyond 1.5 hours. Although the proportion of patients receiving laboratory and radiographic studies will vary, delays of this magnitude can be expected to contribute significantly to long patient visit times. Moreover, because most urgent medical patients have laboratory and/or radiographic studies performed, it is in these patients that laboratory delays have their greatest impact on emergency room times. Reiber's studies[5] confirm a relationship between laboratory and Xray studies and total emergency room time. Although 80% of patients who received no blood tests or Xrays were discharged within two hours, only 42% of those requiring blood tests and 57% of those requiring Xrays were discharged within that time. Only 31% of those requiring both types of tests completed the visit within two hours. It is not clear whether our laboratory and Xray turnaround times are representative of the experience of others. Cue, *et al.*, reported a pooled average time for laboratory tests (blood counts and urinalyses only) of 55 minutes and for Xrays of 44 minutes.[7] Since their study included small suburban and community hospitals as well as large urban hospitals, it is difficult to compare their results to ours.

Admission time, defined as the time required to transfer a patient from the emergency room to a hospital bed following a decision to admit, was frequently prolonged beyond two hours, and correlated with lengthy patient visits. Since approximately 20% of all our patients are admitted to the hospital, a significant fraction are affected by long admission times. Because an even higher percentage of medically urgent patients are admitted, admission times contribute disproportionately to long patient visits within this group. Few other studies have addressed the issue of admission times. In the Washington, D.C. hospitals survey, a pooled average time from registration to admission of approximately three hours was reported.[7]

Conclusion

In conclusion, a time study of patient flow through our emergency services revealed important sources of delay in expediting the evaluation and disposition of patients, particularly those whose problems were deemed most medically urgent. As a result, our department, in conjunction with the offices of laboratory services and of admissions, has been working to shorten laboratory turnover and admission times. Studies from other emergency room settings will be necessary to further assess the importance of these delays in prolonging patient disposition times and in compromising the efficiency of emergency care. ◀

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The Recurrence of Alveolitis in Interstitial Lung Disease

By Nicholas M. DiFilippo, M.S., D.O., F.C.C.P./Oak Lawn

A case report is presented of a 67 year old patient with interstitial lung disease who was treated for one year with high dose steroids and responded adequately to initial therapy. Eight months after steroid therapy was discontinued, alveolitis recurred. This may suggest that intensive steroid therapy for one year may not be adequate in permanently suppressing the alveolitis.

Interstitial lung disease, or cryptogenic fibrosing alveolitis, has recently undergone intensive investigation. A theory of pathogenesis has evolved.[1,2] The susceptibility of the "alveolitis" to steroid therapy has been fairly, although not optimally, successful. The duration of therapy, however, has still not been completely settled. This report concerns a patient with idiopathic pulmonary fibrosis with a very intense alveolitis which responded by complete clearing of the alveolitis (as judged by serial gallium scanning) after prolonged high dose daily steroid therapy. However, eight months after cessation of steroid therapy, the patient exhibited significant clinical deterioration caused by a renewed intense alveolitis.

The patient was a 67 year old white male accountant who presented with complaints of dyspnea and chronic cough. Occupational history was negative for asbestos exposure. Physical exam of this five foot nine inch 202 pound male revealed fibrotic bibasilar rales, clubbing, and cyanosis. Pulmonary function testing obtained an FVC of 2.30L (50% predicted), an FEV1 of 2.04L (71% predicted) and a %FEV1 of 88; TLC was 4.16L (67% predicted); DLCO was 9ml/min/mmHg (37% predicted). Arterial blood gas analysis indicated a pH of 7.43, a pCO2 of 31, and a pO2 of 42. Saturation was 81%. Chest Xray was consistent with very significant interstitial lung disease.

Bronchoalveolar lavage analyzed 83% neutrophils, 10% lymphocytes, and 7% macrophages. Transbronchial lung biopsy did not point to any specific pathology. PPD was positive to 14mm. Significant diffuse uptake was present on gallium scan (4+; liver 3+). The patient was started on 80mg prednisone daily as well as bronchodilators and isoniazid. He was discharged on continuous oxygen via nasal canula. A repeat gallium scan six weeks after initiation of intensive steroid therapy showed almost complete clearing. Serial scans revealed further clearing.

Prednisone was discontinued after one complete year of treatment. A gallium scan four months after discontinuation of prednisone was unchanged, and serial arterial blood gases remained stable. However, eight months after discontinuation of steroids, increasing dyspnea, increased cough, and cyanosis were again present. Arterial blood gas analysis revealed worsening pO2 as well as some slight increase in pCO2. The patient was readmitted because of the increasing FIO2 requirements. Work up showed an unchanged chest Xray and a significantly increased gallium uptake. High dose steroid therapy was again initiated.

Discussion

The treatment of interstitial lung disease is still undergoing intensive investigation. At present, high dose daily steroid therapy remains the treatment of choice.[1] Pulse therapy consisting of once a week high dose (two gram) methylprednisolone coupled with relatively lower prednisone dosage also appears to be acceptable, but has not been as firmly established as the high dose daily regimen.[2] Alternate day therapy has not been proven to be as effective.[1] Length of treatment is highly controversial. Some physicians carry out treatment until the

gallium scan clears, others empirically for one year and still others recommend lifelong therapy.

Our case report would tend to favor the latter approach. This patient was treated with high dose daily prednisone therapy for a period of one year. He responded favorably showing complete clearing of an intensive alveolitis, as judged by serial gallium scans. Clinically, he required a lower FIO2 in order to maintain an adequate pO2. Eight months after complete cessation of prednisone therapy, however, there was a notable clinical deterioration. Cyanosis and a significantly increased FIO2 requirement were present. Chest Xray was unchanged. There was no evidence for such likely possibilities as pneumonia or pulmonary embolus, as the etiologic agents for the deterioration noted clinically. Repeat gallium scan at this time, however, manifested renewed activity limited to the lung area. The intense alveolitis had initially responded adequately to steroid therapy. However, months after prednisone withdrawal the alveolitis once again dominated the clinical picture. The alveolitis was responsible for producing a significant deterioration in the clinical status.

This observation makes long term follow-up of this debilitating disease a critical issue suggesting continuation of serial gallium scans long after therapy has been discontinued. Gallium scan is suggested, since of the two modalities, (bronchoalveolar lavage and gallium scan) it is the less invasive. Although not yet documented, it appears at present that the incidence of interstitial pulmonary fibrosis is rapidly rising. Consequently as more data accumulates, more definitive reccomendations can be made. At this time, however, it would appear that prolonged maintainance therapy is indicated. On the other hand, if steroid therapy is discontinued, close continued clinical observation with serial gallium scan in responders should be the rule. ◀

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Reflections on Giving

By Vivian Reardon, ISMSA President

In this season of warmth and good will, the spirit of generosity pervades our thoughts. Although these thoughts are usually focused on the future, perhaps we should take a moment to reflect on the good that we have done and the care that we have shown over many years.

Forty-four years ago the Benevolence Fund was established out of a recognition that some among us were economically distressed. While not designed for complete support, the fund has provided supplemental assistance for many years. Spouses of deceased physicians and their families have been the most frequent recipients, although financially troubled physicians have also been aided. The monies to provide this aid have been accumulated through donations, direct dues assessment of both auxiliary and medical society members, countless hours of fund raising efforts by auxiliary members, and direct medical society funding. Benevolence has been a lasting example that emphasizes the willingness of our Illinois medical family to care for its own—an appropriate action for a caring profession.

Countless patients throughout Illinois and the U.S. continue to benefit from our generosity to medical schools and medical students. For over 30 years we have helped to support quality education in the nation's medical schools through AMA-ERF. The research supported, the loan programs, the unrestricted funds, have all contributed to excellence in medicine today. Direct contributions and continuing efforts of medical societies and their auxiliaries have produced funds that have averaged over $1 million yearly since the auxiliary became involved in 1955. The AMA-ERF Medical Student Assistance Fund, established in 1983, provides direct medical student assistance for educational expenses. It helps to relieve one of the greatest sources of stress for dedicated students today.

All of these efforts are truly an example of American medicine helping to insure the availability of quality health care for all and also a concern for its own.

In 1983, recognizing a need at home, the Illinois Medical Student Loan Fund was established. Resident and medical student organizations active within ISMS brought attention to the fact that third and fourth year students were in danger of not meeting their financial obligations. Drastically increased tuitions and the exhaustion of outside financial resources proved to be the main source of the problem. In answer, the ISMS created this loan fund for Illinois students in their third or fourth year who were attending Illinois medical schools. Through dues, direct donations and fund raising, the auxiliary and medical society have striven to meet a need. This is another instance when those who have gone before have cared enough to provide for others.

Many physicians and their patients, who are scattered throughout Illinois and the rest of the country, have benefited from our concern. Many are deeply grateful for the energy expended in fund raising, and for the generosity and caring demonstrated by the medical community. Let us all take pride in this generosity and the spirit of support that we have so long demonstrated. Let us recognize this firm foundation of caring as we continue our giving in the future.◀

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EKG

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Answers: 1. A, B 2. A, C

The precordial leads V_1 through V_5 show large Q waves followed by tall R waves and a widened QRS complex to 0.14 seconds. ST segment elevation is present in leads V_2V_3 and V_4. This is an acute anteroseptal wall myocardial infarction with right bundle branch block. Note the deep S waves in leads I and V_6 compatible with right bundle branch block. No P waves are present and the R-R cycles are irregularly irregular for a diagnosis of atrial fibrillation. The QRS complexes are equally tall in leads III and AVF suggesting right axis deviation of approximately +115°. Right axis deviation could be caused by a left posterior hemiblock. In addition to an extensive anteroseptal myocardial infarction, the ECG suggests bilateral bundle branch block, *i.e.*, complete right bundle branch block and left posterior fascicular block. In the multicenter study by Hindman, *et al.*, of 494 patients with bundle branch block and acute myocardial infarction, this ECG pattern of bilateral bundle branch block and acute infarction was associated with a 58% in-hospital and one year follow-up mortality.[1] Hospital mortality was strongly related to congestive heart failure. Seventy-six percent of the in-hospital deaths were the result of power failure. The presence of a previous myocardial infarction was associated with a significantly higher mortality, 42% versus 25% with no old infarction. This ECG pattern of complete right bundle branch block and left posterior hemiblock was seen in 45 of the 494 patients. Although uncommon, this ECG in a patient with congestive heart failure carries a grim prognosis. Worse still, the patient had a cerebral vascular accident. Our neurology consultant thought this might be the result of a cerebral embolus occluding the left middle cerebral or left carotid arteries. The echocardiogram was ordered to detect any mural thrombus. The echo showed left atrial enlargement and right and left ventricular enlargement but no mural thrombus. The echocardiogram is still a sensitive test for the detection of mural thrombi. Weinreich, *et al*, have recently discussed this and feel an apical wall infarction is a prerequisite for the development of mural thrombus.[2] On the fourth hospital day, our patient had a cardiopulmonary arrest and could not be resuscitated.

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1. Hindman, M. C., *et al.*: The Clinical Significance of Bundle Branch Block Complicating Acute Myocardial Infarction," *Circulation* 58:679-688, 1978.
2. Weinreich, D. J., *et al.*: Left Ventricular Mural Thrombi Complicating Acute Myocardial Infarction," *Ann Int Med* 100:789-794, 1984.

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